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ABSTRACT

This monograph advances ideas to aid planners and administrators responsible for the development of deinstitutionalization services for the disabled to develop a more rigorous, systematic approach to the provision of these services. The seven chapters of the publication, each written by a recognized leader in the field, focus on the following: (1) the growth and development, both historically and conceptually, of the deinstitutionalization movement and its impact on human service systems; (2) approaches to identifying, quantifying, and assessing the needs of various populations who might be served through deinstitutionalization programs; (3) sources and mechanisms for funding deinstitutionalization services, with an emphasis on maximizing available federal and state funding; (4) a system-oriented analysis of roles and relationships within and between agencies that provides a basis for improving continuity of care for clients and closer working arrangements between service providers; (5) a review of principles and characteristics of community-based programs and of models that serve the residential, social, and vocational needs of formerly institutionalized clients; (6) emerging issues and trends in the areas of personnel training, development, and use, with special notice given to the changing roles of workers involved in the deinstitutionalization field; and (7) the importance of community attitudes and behaviors toward deinstitutionalized clients and programs, as well as proposed strategies for achieving more positive public acceptance. A final chapter provides a summing up by the editor. (KC)

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Planning for Deinstitutionalization:

A Review of Principles, Methods, and Applications

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Introduction

Since the mid 1960's, a dramatic realignment of ideologies, programs, resources, and community relationships has reshaped many of the major human services delivery systems in the United States. This realignment—which has come to be known as deinstitutionalization—can be described as a movement or public policy designed to reassign or discharge to the community persons who otherwise would have entered and/or remained in an institution. Deinstitutionalization has produced sweeping changes in the organization, sequence, and content of care provided to disabled individuals seeking to attain a stable adjustment in society. It has affected the methods and focus of treatment as well as a variety of funding, staffing, and legislative mechanisms associated with the provision of services. Its most important impact, of course, has been on the community careers of the individuals themselves—a sector of our population numbering in the millions and bound by the common experience of having suffered a mental, physical, or social impairment serious enough to require admission into an institution.

This monograph is offered with the goal of aiding and abetting a more rigorous, systematic approach to the development of deinstitutionalization services. It is intended to assist planners and administrators responsible for the provision of community-based care by presenting indepth discussions of principles and methodologies that are central to effective programming.

Specifically, its chapters focus on:

- the growth and development, both historically and conceptually, of the deinstitutionalization movement and its impact on human service systems;
- approaches to identifying, quantifying, and assessing the needs of various populations who might be served through deinstitutionalization programs;
- sources and mechanisms for funding deinstitutionalization services, with an emphasis on maximizing available Federal and State funding streams;
- a system-oriented analysis of roles and relationships within and between agencies that provides a basis for improving continuity of care for clients and closer working arrangements between service providers;
- a review of principles and characteristics of community-based programs and of models that serve the residential, social, and vocational needs of formerly institutionalized clients;
- emerging issues and trends in the areas of manpower training, development, and utilization, with special notice given to the changing roles of workers involved in the deinstitutionalization field;
- the importance of community attitudes and behaviors toward deinstitutionalized clients and programs, as well as proposed strategies for achieving more positive public acceptance.

Each chapter was written by a recognized leader in his or her respective field. Together with the Closing Comments, they should put deinstitutionalization into a perspective that allows effective planning for coming social changes.

Principles, Methods, and Applications

I. Deinstitutionalization: Development and Theoretical Perspective

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Introduction

The term "deinstitutionalization" has been used to refer to recent efforts to reverse the trend of providing treatment or care for certain dependent populations in environments physically separated from their home communities. Closely related to such notions as "normalization" (Wolfensberger, 1970) and "mainstreaming" (Anonymous, 1977; Omang, 1979; Silverman, 1979), deinstitutionalization efforts have been pursued for a variety of target populations, including the chronically mentally ill; the developmentally disabled; the elderly; the physically handicapped; and juvenile and adult criminal offenders. Generally speaking, the physical isolation characterizing traditional treatment and services for these populations has been accompanied by social isolation. By definition institutional care is provided away from the mainstream of society, and the people affected by that care have different kinds of social exposures and social environments from the majority of the population.

This discussion examines the development of the deinstitutionalization movement and its implications for public policy formulation. Starting with a review of the scope of the problem and the meaning of deinstitutionalization, the chapter then proceeds to an examination of the problems that have been encountered in planning and implementing deinstitutionalization efforts. It continues with an exploration of recent planning trends for deinstitutionalization programming and concludes with some observations on systems considerations for deinstitutionalization.

Scope of the Problem

This chapter reviews the recent literature on deinstitutionalization. Because deinstitutionalization efforts are most closely identified with programs for the severely mentally disabled—the mentally retarded and the chronically mentally ill—the chapter is primarily concerned with those populations. However, the dynamics of service provision for some of the other target groups of the deinstitutionalization movement are sufficiently similar to those for the mentally disabled to permit extensive generalizations from that literature. At various points in this discussion attempts will be made to demonstrate this generalizability by including evidence from the deinstitutionalization experience of the physically disabled and the elderly. On the other hand, since deinstitutionalization efforts on behalf of juvenile and adult criminal

offenders tend to depart from somewhat different program goals from those for the mentally disabled (National Council, 1979; Rose, 1979), the observations made here have only limited applicability to those target groups, and no attempts at generalization will be made.

The plight of the severely mentally disabled is of particular importance to the delivery of human services. Not only are programs for the mentally retarded and the chronically mentally ill regularly listed in current human service taxonomies, but it is widely documented that these populations, with their peculiar combination of diverse service requirements, chronicity, and impotence, have a desperate need for access to the full range of human services. Indeed, caring for those who are severely mentally disabled may be viewed as a prototype for human service delivery procedures and has been used generally to illustrate issues associated with the delivery of human services. (Bachrach, in press e)

The literature on deinstitutionalization is extensive and ranges from popular reports in the daily press to highly theoretical discussions in the scientific literature. Some of that literature is oriented toward the design of relevant and practicable programs for specific target populations. For the most part, these reports of program planning are categorical in nature, and the literature indicates surprisingly little exchange among target populations.

In a very real sense, this is a loss. While program plans and the concepts underlying them remain distinct and awaiting synthesis, exchange could potentially be quite productive. Research in mental retardation, for example, has explored a number of areas that are of major concern to planners of services for the chronically mentally ill. There is a body of literature in the field of retardation that is rich with techniques for assessing both client needs and client satisfaction. Similarly, new directions in programming for the retarded have yielded a variety of effective rehabilitation protocols. Planners of programs for the chronically mentally ill are only now beginning to focus in depth on these practical and basic concerns. (Anthony, 1977, 1980) They might potentially avoid considerable trial and error by careful study of the procedures developed in the field of mental retardation for these and other programmatic concerns.

On the other hand, the massive depopulation of institutions for the mentally ill, which both predates and outnumbers that for the retarded, can now be viewed with something approaching historical detachment. The mental health literature is replete with analyses of the sociopolitical dimensions of deinstitutionalization. And many of the planning and implementation difficulties that are currently surfacing in the literature on deinstitutionalization of the developmentally disabled have a *deja vu* quality for readers who have encountered similar problems in planning for the chronically mentally ill.

These observations are in no way intended to minimize the differences among the various target populations affected by the deinstitutionalization movement. There are certainly major distinctions among these groups, and it appears that viewing them as if their problems are identical may even have the unintended effect of diluting their individual bases of support. The *New York Times* reports, for example, that the success of a program for hiring mentally retarded individuals in noncompetitive municipal jobs in New York City has been slowed, because agency supervisors "mix them up with those who are emotionally disturbed." (Gupte, 1977) In the strong language of the Liaison Task Panel on Mental Retardation (1978) of the President's Commission on Mental Health, the confusion between mental illness and mental retardation "has had unfortunate consequences for retarded people and their families. It has led to public misunderstandings and has fostered inappropriate professional services and administrative models."

There are, of course, some individuals who are both mentally retarded and mentally ill (Bachrach, in press c), and, although they represent a relatively small portion of both universes, the Liaison Task Panel (1978) devotes the bulk of its report to their treatment needs. Those in this special population who receive human services are sometimes treated in the mental health service system and sometimes in the mental retardation service system. Except, however, for this uniquely afflicted group, the chronically mentally ill and the mentally re-

tarded have tended in the past to be separated physically in treatment settings, although the deinstitutionalization movement may now be bringing them together in increasing numbers.

It is a basic assumption of this chapter that it is possible to view the social processes that affect program planning for the various target populations of deinstitutionalization simultaneously without doing violence to their individuality. Since deinstitutionalization is very much a sociological series of events, with certain attributes pertaining to the process irrespective of what particular persons undergo it, it is possible to distill some of its conceptual elements. Separate as the target populations may be, problems in planning for them converge at a number of points.

Thus, for example, a recent article in the *New York Times* reports that 40,000 physically and/or mentally disabled elderly persons reside in some 3,500 community-based residences in the vicinity of Asbury Park, N.J. While only between 40 percent and 65 percent of these persons are former mental patients, the entire population shares in similar survival problems: "The homes have no doctors on their premises and few programs for daily recreation or mental, physical, and vocational rehabilitation. Medication—a vital regimen for many inhabitants—is often dispensed by people without medical or psychiatric training." (Hanley, 1981)

Background

Today certain basic circumstances are widely understood to strain the provision of services targeted toward deinstitutionalized populations. First, individuals suffering from severe mental disabilities are characterized by a wide range of disabilities and service needs which often endure as lifelong conditions. In sharp contrast to the breadth and variety of these needs, service delivery tends to be planned with a view toward pragmatic simplicity. With respect to the chronically mentally ill, Hansell (1978) suggests that community-based programs in general place an "unwarranted emphasis on the single-episode user of services" and thus exhibit a "deficiency of interest in people with lifelong disorders."

Second, many programs ostensibly designed as deinstitutionalization programs resist treating those individuals who are most severely impaired and thus are not realistically directed toward their needs. (Link and Milcarek, 1980; Stern and Minkoff, 1979; Task Panel, 1978) For example, Halpern and his associates (1978, p. 19) draw the parallel that "expecting the chronically mentally ill patient to use the current mental health system is like expecting a paraplegic to use stairs. The [chronic] patient can't use the current mental health system because it's oriented toward people who have motivation, who have the capacity to develop insights, to change behaviors, to accomodate through socially acceptable behaviors"—characteristics not generally descriptive of the severely mentally impaired. Miller (1977) writes of an "inverse system of care," in which "the most trained and skilled clinicians deal with the most articulate, interesting, and likely-to-succeed clientele," while the plight of those persons most in need is largely ignored.

Third, the delivery of community-based services to the severely mentally impaired takes place against a backdrop of stigma exceedingly difficult to penetrate. (Bruininks, et al., 1980; Budson, 1979; Dokecki, et al., 1977; Johnson, 1980; President's Commission, 1978; Stern and Minkoff, 1979; Taber, 1980; Talbott, 1980)

Fourth, fragmentation of services and authority in addressing the needs of the severely mentally disabled is a serious and difficult problem reducing the quality of care. (Bachrach, 1976, 1979; President's Commission, 1978; U.S. General Accounting Office, 1977a, 1979, 1980) In past years, most persons with severe mental disabilities were admitted to large institutions, where most remained, often for the rest of their lives. They represented an essentially static population pool that changed primarily as the result of new admissions and deaths. Providing care was relatively simple: virtually all services could be delivered within a single physical

setting. Today, by contrast, authority for providing for the needs of disabled persons is divided among numerous health, educational, and human service agencies in the public and private sectors. Successful deinstitutionalization programs require the fine tuning of initiatives that originate with separate, sometimes competing, authorities—a process far more complicated than what was suggested in John F. Kennedy's (1963) "bold new approach" to service provision.

Fifth, deinstitutionalization programs are designed and implemented within a context of semantic confusion that both reflects and sustains service delivery problems. (Bachrach, 1980a, in press b, in press d; Carpenter, 1978; Moos and Igra, 1980; Peele and Keisling, 1980) A potent barrier to effective care, conceptual vagueness results from and underscores a general failure to assess adequately the complexities attending deinstitutionalization.

Toward a Definition of Deinstitutionalization

That deinstitutionalization is a complex phenomenon with many facets is frequently overlooked. The educational psychologist in the State school, for example, is bound to have a perspective on it differing materially from that of the public school teacher who is trying, with inadequate funds, to mainstream retarded children. Similarly, the term undoubtedly has different connotations for the institution-based psychiatrist, the community-based mental health nurse making a home visit, and the mental health program evaluator who is attempting to make sense of difficult-to-trace patient movements. The term is certainly variously understood by the many clients who are affected by it—those who have been institutionalized for several decades and whose future continues to be linked to institutional care; those who are about to be released to the community after varying periods of residence within institutions; and those whose admission or readmission to an institution is effectively barred by admission diversion policies. (Dionne, 1978; Sullivan, 1979a, 1979b)

Any working definition of deinstitutionalization must be sufficiently abstract to accommodate differences in individual experience and thus allow for these divergent points of view. Toward that end, deinstitutionalization is defined, for purposes of this discussion, as a process involving two elements: the eschewal, shunning, or avoidance of traditional institutional settings for the care of the severely mentally or physically disabled; and the concurrent expansion of noninstitutional, community-based facilities for the care of these populations.

The important point in this definition of deinstitutionalization is that it is a mistake to view the process unidimensionally, as if it refers exclusively to clients leaving institutional environments. We shall presently see that deinstitutionalization is a much broader event even affecting clients—actual and potential—who have never been institutionalized.

Implicit in this conceptualization of deinstitutionalization is the notion that sociological as well as physical phenomena are involved. Physically, deinstitutionalization refers to the creation of new environments for the severely disabled. It is a geographical phenomenon that is reflected in the rapid and continuing depopulation of large institutions, as well as in the increasing expansion of community-based facilities. Sociologically, the concept of deinstitutionalization implies widespread adjustments in traditional patterns of care for this basically dependent and disabled population.

Aspects of Deinstitutionalization

There are at least three separate, but closely related, aspects of deinstitutionalization. Deinstitutionalization is a process; it is a philosophy; and it is also a fact.

Deinstitutionalization as Process

More than the simple depopulation of large public facilities, deinstitutionalization may be understood as a dynamic and continuing series of adjustments involving constant accommodation of all the components of the service delivery system. The concept of continuity of care suggests the dynamic nature of deinstitutionalization. Ideally, at least, with deinstitutionalization the client is expected to move about freely from facility to facility, even in and out of the service system. Utilization of facilities is supposed to be determined by the client's current needs in a free market model: as service needs change, so will patterns of care.

Because of the dynamic nature of deinstitutionalization, disabled persons are today found in a wide variety of physical settings. An analysis of the changing demography of chronically mentally ill individuals reveals that at least five separate target population subgroups may be identified as being affected by the deinstitutionalization movement, two in the community and three in institutional settings. (Bachrach, 1978)

A first subgroup within the target population consists of institutional dischargees who are currently in the community. Although these clients are the ones most often identified with the term deinstitutionalization, they are by no means the only persons affected by the movement and make up only a portion of the target population. They coexist in the community with another subgroup, never-institutionalized individuals, who probably would have been placed in institutions several decades ago and who, as the direct result of deinstitutionalization policies and practices, represent an ever-increasing percentage of the target population. The medical, psychiatric, and social service needs of never-institutionalized individuals may be very different from those of institutional dischargees.

At the same time, deinstitutionalization has also affected patterns of care for a variety of clients who, despite deinstitutionalization efforts, continue to utilize institutions. (Kugel and Shearer, 1976; Thorsheim and Bruininks, 1978; Witkin, 1980) A third subgroup of the target population consists of old long-stay clients, veteran residents of institutions who were admitted long ago and who continue their residence despite the trend toward community-based care. In both institutions for the mentally ill and the mentally retarded, old long-stay clients frequently represent a substantial percentage of the enrollment. It is also interesting to note that that special population diagnosed as mentally retarded who reside in institutions for the mentally ill sometimes make up a considerable portion of hospitals' old long-stay clients. Unpublished data from North Carolina's Department of Health and Mental Retardation for 1978 indicate, for example, a strong correlation between length of stay and percentage of residents who are retarded, so that fewer than 5 percent of residents with stays of one year or less but 31 percent of residents with stays of 20 to 40 years are so classified.

The institution also contains a fourth subgroup, short-stay clients, who will soon be released to the community. According to unpublished estimates from the National Institute of Mental Health (NIMH), nearly one-quarter of admissions to State mental hospitals are released within a week of admission, and nearly 40 percent are released with 14 days of entering the hospital.

Finally, the institution contains a fifth subgroup, new long-stay clients, who represent a buildup of long-term residents from among recent admissions who are unlikely to be considered good risks for community care and probably will not be released. Literature on both the mentally ill and the mentally retarded refers to a core of new admissions who are expected to remain institutionalized for reasons related to their mental and/or physical status and to the inability of their home communities to serve them.

The boundaries of these five subgroups are fluid in varying degrees, and the revolving door phenomenon may be understood conceptually as their ongoing realignment.

Although current planning initiatives tend to stress "aftercare"—i.e., services for persons who are institutional dischargees—programming for deinstitutionalization should, ideally,

accommodate all five of these subgroups, not only discharged individuals. Because each subgroup in its own way represents fallout from the deinstitutionalization movement, individuals in all of them must be regarded as legitimate beneficiaries of planning efforts directed toward improving care. At a time when financial constraints make it necessary to be as parsimonious as possible, we are thus faced with the task of arranging a multitude of services for a variety of client groupings in numerous settings. And, in reality, our planning efforts have been spread so thin that, on a nationwide basis, none of these subgroups appears to be receiving adequate coverage in planning efforts.

Deinstitutionalization as Philosophy

When we view deinstitutionalization as a process, we can begin to understand something of its intellectual foundation. The rationale for deinstitutionalization proceeds from several fundamental, and largely untested, assumptions concerning community-based care. First, there is an assumption that community care is a good thing and is preferable to institutional care for most, if not all, mentally disabled clients. A second underlying assumption is that communities not only can but also are willing to assume responsibility and leadership in the care of the most seriously disabled. And a third assumption regarding deinstitutionalization is that the functions performed by institutions can be equally well, if not better, performed in community-based facilities. It is believed, in short, that the community is capable of providing the same range of services that is available inside the institution.

These three assumptions taken together lead to an understanding of the goal of deinstitutionalization. Deinstitutionalization has undertaken no less a task than that of "humanizing" care for the severely mentally and physically disabled—of reversing the dehumanizing influences that are widely thought to be accompaniments of institutional residence. Since its inception, deinstitutionalization has, in fact, been identified with the generalized social reform ideology that reached its peak expression in the 1960's. That ideology stresses society's responsibility to help the individual and places a strong emphasis on civil rights; modification of the environment is understood as the primary avenue toward social betterment. (Hersch, 1972) In its broadest sense, then, deinstitutionalization is properly understood as a protest movement. Like other civil rights protests, it is ideologically committed to improving the lot of persons who are seen as helpless in gaining access to life's entitlements. It is a movement dedicated to the dignity of the individuals, and it emphasizes the rights of dependent individuals and their legitimate claims on society.

This ideological commitment to social reform is particularly evident in the literature on deinstitutionalization of the mentally retarded. While a number of factors exclusive of the social reform ideology are credited with propelling deinstitutionalization for the chronically mentally ill—including the introduction of antipsychotic medications to control the symptoms of mental illness and the development of crisis intervention techniques in psychiatry (Smith and Hart, 1975; Talbott, 1978)—the civil rights ideology has largely been responsible for deinstitutionalization of the mentally retarded. (Silverman, 1979) Roos (1975) classifies the major civil rights issues for the mentally retarded into three categories: the right to education, the right to treatment, and freedom from peonage. To these may be added the right to care and residence in the least restrictive setting. (Thurlow, et al., 1978)

However, it is important to note that deinstitutionalization also owes much of its popularity to its appeal to more conservative forces. Acceptance of the progressive philosophy of deinstitutionalization has been facilitated by its attractiveness to persons who are more interested in fiscal reform than social reform— a situation making for strange bedfellows among the movement's proponents. Deinstitutionalization was, when the movement began, and continues to be widely believed to be cheaper than institutional care, and this belief has made the movement acceptable to many who might otherwise oppose it.

In addition to the presumption of cost savings in community-based care, there has also been

a desire on the part of State legislatures to reduce their budgets by "shifting the cost and responsibility of the formerly institutionalized to a different level of government." (Cramer, 1978) With the depopulation of large institutions many disabled persons have relied on Federal public assistance funds for support. It is not difficult for States to justify reduced fiscal responsibility in light of what is regarded so widely within the helping professions as a more humane system of care.

In short, the fact that the philosophy of deinstitutionalization is allied with a coalition of opposing or contradictory political sentiments in large part accounts for the rapid spread of the movement. Recent economic developments have, however, suggested that the wedding of these different views is coming to an end and that the ideological commitment to deinstitutionalization is being diluted. Unqualified support is increasingly difficult to find. The philosophical basis for deinstitutionalization, being subject to the fickleness of political winds, particularly in times of inflationary stress, is fragile.

Some of the ideological shift has to do with the fact that the fiscal superiority of deinstitutionalization has never been firmly established. (Cramer, 1978; Rose, 1979; Talbott, 1980) A recent report from the U.S. General Accounting Office (1977b), for example, indicates an inverse relationship between degree of impairment among the elderly and the costs of community care. For both the mentally retarded and the chronically mentally ill, it is being increasingly acknowledged that high-quality care is not rendered inexpensive when the locus is shifted from the institution to the community. Not only is the cost of community-based care in programs providing a full range of specialized services high (Weisbrod et al., 1980) but, beyond a certain point in resident population reduction, the per capita costs of running an institution must obviously increase. (Holden, 1979) The savings that were supposed to accompany the depopulation of institutions simply have not materialized on a nationwide basis.

Deinstitutionalization as Fact

In addition to its being a process and a philosophy, deinstitutionalization is a fact with some measurable dimensions. That it really is occurring is reflected in nationwide statistics concerning the depopulation of large institutions. For the chronically mentally ill there has been a marked decrease in the resident population of the Nation's State mental hospitals. That population peaked in 1955 at 558,992. Ten years later it stood at 475,202 and 20 years later at 193,436. Thus, the resident population of these facilities showed a decrease of 15 percent over one decade and a striking reduction of 65 percent over two decades. (Division of Biometry, 1979) The most recent NIMH statistic for the resident population of State mental hospitals indicates that at the beginning of 1977 170,619 individuals lived in these facilities. (Witkin, 1979)

Deinstitutionalization of the mentally retarded is also reflected in institutional depopulation statistics, although there are notable differences between them and those of the chronically mentally ill. Resident population in public facilities for the retarded peaked 12 years later than that in State hospitals for the mentally ill. In 1967, the peak year, the resident population in institutions for the mentally retarded stood at 193,183 (Butterfield, 1976) and at 148,752 a decade later (Krantz, et al., 1978)—a decrease of 23 percent in 10 years.

Issues in Deinstitutionalization

The perspective that deinstitutionalization is a process and a philosophy as well as a fact permits a better understanding of the problems that are associated with the movement. Were deinstitutionalization merely concerned with the exchange of settings for service delivery, many of the problems known to exist would not have arisen. The community would simply have replaced the institution as the locus of care, and resultant problems would have been of a

logistical nature, easily negotiated and resolved.

The fact is, however, that the deinstitutionalization movement has encountered a succession of difficulties. In addition to fiscal disappointments, numerous other issues have affected the movement. These issues have been discussed at length in the literature; they include problems related to the selection of patients for community care, the treatment course of patients in the community, the quality of life of patients in the community, personnel recruitment and retention, fragmentation of services, financial constraints, legal and ethical problems, and accountability, as well as issues related to the concerns of the greater community. (Bachrach, 1976, in press b) Examination of the literature on deinstitutionalization of the mentally retarded reveals very substantial similarities in the deinstitutionalization problems of the two populations (Bruininks, et al., 1978; Thurlow, et al., 1978; U.S.D.H.H.S., 1980), despite major differences in volume and timing of institutional depopulation.

Thus, Gettings (1977), writing about the fragmentation of services for the mentally retarded, reports that "each federal agency with an actual or potential impact on deinstitutionalization of the mentally retarded tends to develop its operational policies with limited regard to their impact upon ancillary programs operated by other federal and state agencies and with little or no sensitivity to the overall impact of the federal government's efforts at the state and local levels." These words might easily have been written about programs for the chronically mentally ill—or, for that matter, the elderly or the physically handicapped. Similarly, two newspaper articles report, respectively, that the Civil Service Employees Association is protesting the movement of mentally retarded clients from a government facility on Governor's Island, New York to a privately operated medical rehabilitation program, and that suburban residents are resisting the presence of a halfway house for the retarded in their neighborhood. (Kihss, 1978; Weiner, 1976) Once again, these discussions are practically indistinguishable from similar ones in the literature on the chronically mentally ill.

Problems surrounding implementation of the 1975 Education for All Handicapped Children Law (P.L. 94-142) are given extensive coverage in both popular and professional literature. (Anonymous, 1977; Borger, 1977; Diehl, 1979; Gettings, 1977; Huey, 1978; Krucoff, 1979; McCaffrey and Higgins, 1977; Silverman, 1979) The problem of precipitate implementation of program plans is of great concern in this connection, as illustrated in the following statement in the *Washington Post*: "The law has created as many problems as solutions, bringing friction between local school districts and Washington, between parents and schools and sometimes between teachers and teachers, to say nothing of the effects on children. When President Ford signed this legislation . . . he complained about its boundless ambition,'Unfortunately, this bill promises more than the federal government can deliver.' He signed it, nevertheless, and the good intentions became a promissory note that is proving very hard to make good." (Omang, 1979)

Because of the concordance in discussions of issues affecting mental illness and mental retardation, there is ample reason to conclude that the extent to which we view the deinstitutionalization problems of these two target populations as separate and distinct is a matter of perspective. Despite differences in kinds of impairment and in clinical course, and notwithstanding the possibility that concentrating on the needs of one group may at times prove detrimental to the other, there is a level of abstraction at which the issues in deinstitutionalization of the chronically mentally ill and the mentally retarded—and those of the physically handicapped and the elderly (Kane and Kane 1980; Shapiro, et al. 1980; Taber, 1980; Weissert, 1978)—come together.

The perspective that deinstitutionalization involves more than a shift in the locus of care, that it is also a process and a philosophy, helps us to understand an apparent contradiction. While many residents have been removed from large institutions to community-based, board-and-care facilities and nursing homes (Redick, 1974; Taube, et al., 1978), these changes in residence have not necessarily been accompanied by changes in kind and/or quality of care. (Anderson, 1974; Lamb and Goertzel, 1971; U.S. Senate, 1976) Indeed, there is substantial

documentation of neglect for the population residing in many of these "alternate" facilities, and it is not an exaggeration to say that institutionalism (Goffman, 1961) seems to pursue them: that they remain essentially institutionalized, sometimes "reinstitutionalized," or "transinstitutionalized" individuals (Taube, et al., 1978), wherever they are placed.

This situation holds for all target groups of deinstitutionalization among whom substantial numbers have been placed in "community" settings where, ironically, they have little or no access to the benefits of community living. It is, however, most vividly thrown into relief in descriptions of living circumstances among the elderly, with or without mental impairment, around whom a for-profit industry, with what is widely believed to be inadequate regulatory control, has developed (Anderson 1974; Jellinek and Tennstedt, 1980; Tauhe, et al., 1978; U.S. Senate, 1976)

In the discussion of deinstitutionalization as philosophy above, it was noted that an underlying yet untested assumption of the movement is that the functions performed by traditional institutions can be equally well, if not better, performed by community-based facilities. It behooves us to inquire as to what, exactly, these functions are. A review of the literature on the chronically mentally ill suggests that the array of functions performed in institutions for their residence is surprisingly complex and is far more extensive than might at first glance be supposed. (Bachrach, 1976) An attempt to isolate the functions of institutions for the chronically mentally ill reveals a number of items related both to patients and to other sectors of society. In addition to such familiar functions as providing long-term medical and psychiatric treatment for chronically disturbed individuals and providing crisis intervention for patients undergoing acute stress, mental hospitals perform some less readily perceived or acknowledged functions—such as providing for the patient respite from mounting pressures; or protecting him from exploitation by others; or supplying a social structure within which his role is clearly defined; or serving as the means by which society can easily segregate some of its deviants; or serving as an economic base for many communities. This sampling of State mental hospital functions corresponds closely to the functions performed by institutions for the mentally retarded. (Paul, et al., 1977)

Analysis of the literature on deinstitutionalization reveals that the issues associated with that movement and the functions of institutions bear a special relationship to one another. (Bachrach, 1976) Individual issues either have at least one referent among the identified functions, or else they have come into being as unanticipated consequences of the deinstitutionalization movement. The message is clear that deinstitutionalization planning has often taken place in a functional vacuum and that efforts to reduce the stature of or to eliminate institutions have too frequently not heeded the necessity for providing alternatives for the full range of functions involved in institutional care. Not even the central functions of treatment and asylum have been assured for deinstitutionalized individuals, not to mention the various other functions that institutions have been able to provide. (Bachrach, 1976, in press b)

It is apparent that the zeal and dedication that have motivated deinstitutionalization have left in their wake a series of dysfunctional elements resulting directly from rapid and sometimes careless implementation of incomplete program plans. A variety of serious problems have arisen as the result of precipitate efforts to implement the deinstitutionalization philosophy. In their haste to move quickly on behalf of the mentally disabled, service planners have frequently confused locus of care with quality of care. And there has been a marked tendency for the philosophy, the process, and the fact of deinstitutionalization to be disjunctive, as illustrated by the failure to have adequate community-based service structures in place before widespread institutional depopulation and admission diversion plans have been effected. Inadequate planning has simply left too many cracks through which clients can fall.

Effective deinstitutionalization for both the mentally retarded and the chronically mentally ill must obviously rest upon the premise of freedom of choice—the idea of a spectrum of treatment alternatives—by which clients requiring care may choose from among a range of

readily available services. Freedom of choice, in turn, requires the presence of a full range of adequate, fully staffed, and administratively integrated service structures. Generally speaking, however, deinstitutionalization planning has not been conducive to continuity of care of clients. It has too often taken place without the prior development of necessary community-based resources, particularly for those individuals who are most severely handicapped, and without sufficient interagency linkages. It has certainly failed to address adequately the needs of all five client subgroups identified as comprising the target population. It is a sad but nonetheless accurate observation that, in this era of deinstitutionalization, individuals requiring intensive and sustained care have all too frequently had nowhere to turn.

New Directions in Planning

It is not an exaggeration to characterize the deinstitutionalization movement as one that is beset by questions without answers and by answers without questions. (Bachrach, 1980a) Means and ends are frequently confused, and it is hardly surprising that many planners and caregivers are today questioning both the assumptions and the procedures of past deinstitutionalization efforts. While the commitment to maximizing community-based opportunities for the mentally disabled, the physically disabled, and the elderly remains strong in many quarters, new directions in deinstitutionalization planning are attempting to take cognizance of some of the unanticipated consequences of moving too rapidly, and methods are being developed for improved continuity of care and for better interagency communication. At the same time, many proponents of deinstitutionalization have become somewhat less fixed in their thinking than they were several decades ago and are attempting to accommodate, rather than eliminate, the role of public institutions in the spectrum of services for the most severely disabled. There is increasing understanding that, because institutionalism may occur in community-based facilities as well as in large institutions unless individual clients' needs are carefully assessed and met, where clients receive care is of lesser importance than what happens to them. In addition, there is evidence that institution-based programs are also capable of sensitivity and relevance in caring for the disabled, and a number of them are exhibiting innovative and humane programming. (Bachrach, 1980a; Kane and Kane, 1980; Morrissey, et al., 1980; Peele, et al., 1977; Steel, 1980)

Thus, increased tolerance of the role of institutions is appearing in the literature on deinstitutionalization. Dokecki and his colleagues (1977) write that a broad civil libertarian understanding of the charge of deinstitutionalization for the mentally retarded implies that the process may to some degree "be accomplished within the institution as well as beyond its walls and jurisdiction." Just as there are certain mentally ill persons who continue to require institution-based services (Rachlin, 1976), so there is, at the present time, a group of mentally retarded individuals who "cannot fit into community programs or into family situations," and this group "is large enough to create pressure for more institutional construction." (Jaslow and Spagna, 1977) Pappas and her associates (1976) summarize this changing perspective on the role of institutions: "To deinstitutionalize persons does not mean to simply move them out of state hospitals and into community placements. It refers to more than the collection of buildings commonly called 'institutions.' Instead, deinstitutionalization deals with the process of opening up less routinized and more varied behaviors for both individuals and settings, no matter what the facility or where it is."

This recent emphasis on planning for individual clients' needs irrespective of locus of care may be expected to alter the direction and the speed of future deinstitutionalization efforts. The most recent deinstitutionalization literature demonstrates increasing awareness of the complexities of program planning, and recognition of the full range of functions associated with institutional care is becoming more prevalent.

In the early years of social policy formulation in deinstitutionalization, the need for developing community-based "model programs" for the care of the severely disabled was stressed.

Planners sought to develop model programs to be reproduced in other settings. It is being increasingly recognized today, however, that although model programs have valuable research potential, their replicability is often quite limited for a variety of sociological and economic reasons. Moreover, these programs sometimes tend to be limited in concept and highly selective in their target populations, so that they cannot provide ready solutions to the global problems that are associated with the deinstitutionalization movement. (Bachrach, 1980b)

Although some planners continue to stress the development of model programs as solutions for the varied problems of deinstitutionalization, discrepancies between individual successful model endeavors and service system "failures" are becoming apparent. As a consequence, the need for new systems-oriented planning strategies is increasingly recognized. In response to that need, a growing body of literature on the essentials of comprehensive deinstitutionalization programming is now beginning to emerge.

Some Principles

It is generally agreed that, to provide humane services that are relevant to the needs of disabled persons, the planning of community-based efforts must depart from certain interrelated principles. One of these is the need for precision in the statement of program goals and objectives. (Bachrach, 1974; Hagedorn, 1977; Rossi, 1978; Rossi, et al., 1979) Having definite and commonly understood goals and objectives is closely tied to the need to define target populations with care. It is becoming increasingly clear that one of the first steps in implementing successful deinstitutionalization programs must be the specific determination of who, i.e., which clients, are to be treated in the community. A corollary question is: Are there some clients who cannot be regarded as "good risks" or as appropriate candidates for community care? And, if there are, where and how shall they be treated? The answers to these questions depend largely on the specific community involved and on the special resources that it has. The answers also depend on timing. Some communities are at any given moment better equipped—in terms of available services, personnel, and attitudes—to support deinstitutionalization efforts than are others. The fact that a community does not demonstrate immediate readiness does not necessarily indicate a permanent state of affairs. Lack of readiness may be a temporary phenomenon awaiting the careful design of program plans. Or it may be virually permanent if the community foresees no way of providing alternatives for institutional functions. Isolated rural communities may be particularly hard pressed to supply these alternatives. (Bachrach, 1977, in press f)

The definition of the target population must be consistent with the goals of the various agencies involved in a deinstitutionalization program plan. The multiplicity of agencies and auspices typically found in such efforts leads to a second principle: the need for cooperation, communication, and linkages among the agencies and personnel providing services. (Bachrach, 1979; O'Connor, 1976; Schalock, 1979) Resource linkage is essential for integrating service delivery, for avoiding duplication of services, for controlling or reducing service delivery costs, and for countering turf-related opposition to programs among special interest groups. (Hagedorn, 1977)

However, it is essential that efforts to establish resource linkages not be confused with a quest for regulated coordination and blurring of agencies' identities. There are genuine categorical differences in clients' needs, and the possibility that separate and highly focused programs may at times be more responsive to these differences should not be overlooked.

A third basic planning principle revolves around the need for individualized program plans. Potentially, deinstitutionalization programming may proceed in a number of ways, some of them more, some less, sensitive to the needs of individual clients. The least sensitive planning, which is not properly described as planning at all even though it often passes as such, makes

little effort to match clients and settings. It is, instead, wholesale placement of clients without consideration for their special needs. Such placement may occur either in an institution or in the community, and it leads to what is popularly called "dumping."

Effective planning begins to take place when an effort is made to correlate clients and settings. The simplest kind of matching involves studying the client's level of functioning and attempting to place him in the setting most compatible with that level. But deinstitutionalization is most sensitive and meaningful if it carries the process one step further so as to enhance, where appropriate, the client's skill development. With an individualized "skills training" or rehabilitation approach (Anthony, 1977, 1980), placement is based on the client's potential rather than on his current level of functioning. And his capabilities, not his disabilities, are emphasized.

There are, of course, some clients who, with the current state of our technology, are not appropriate candidates for skills training. It is essential that their care be assured as part of deinstitutionalization planning, too. The important point is that programming must be individually prescribed. As with the notion of continuity of care, the primary emphasis in program development should be on individual clients' needs and not on the mechanisms that hold the "system" together—a concept that sometimes gets lost in preoccupation with administrative flow charts and service descriptions. (Bachrach, in press d)

Individualized programming necessarily activates certain other elements of care that are fundamental to the provision of humane and relevant deinstitutionalization services. Program elements like 24-hour crisis intervention and case management, specifically discussed in much of the literature on deinstitutionalization, are automatically assumed and assured when the principle of individualized programming is at work.

An additional planning principle centers on the necessity for collecting useful information about clients and services. (Bachrach, 1979; Bruininks, et al. 1980) This principle should not be construed as urging the amassing of large quantities of data; volume is unimportant, and it is the usefulness of the data that is critical in deinstitutionalization program planning. Although it is a truism that "good decisions require good information" (Ryan, 1979), the development of sensitive and adequate information systems for purposes of resource monitoring, client tracking, and program evaluation has frequently lagged in deinstitutionalization efforts.

Particularly because so many different agencies are typically involved in deinstitutionalization programs, and because so many clients require what have come to be known as "outreach" services, it is necessary to keep in touch with who and where potential and actual service recipients are and what configurations their needs take. Thus, client tracking is of particular concern. The difficulties that surround maintaining adequate tracking data are, in reality, symptomatic of a much deeper problem, that of not knowing where clients are. If deinstitutionalization programs are to reach out to clients to help them receive entitlements and appropriate services, they must, very simply, know how to find the people in the target population.

Conclusions

These and other planning principles in deinstitutionalization (Bachrach, 1979, 1980b, in press e) support the adoption of new planning strategies. To that end, a number of recent articles have recommended the application of systems theory principles in developing deinstitutionalization programs for the severely mentally disabled. (Bradley, 1978; Holder, 1977; Johnson, 1980; Marmor, 1975; Stratas and Boyd, in press) The literature is now beginning to explore some systems issues that must be resolved if deinstitutionalization efforts are to meet with success, and disabled populations are to be cared for humanely in the community.

One recent conceptualization by Johnson (1980) defines the systems context of mental health services in terms of four environments: (1) the core level environment of the agency itself, with its distinctive charter and mandates; (2) the specific environment, including the agencies, associations, and individuals interacting with the core level agency, such as patients' families, hospitals, and other health and human service agencies; (3) the supportive environment, including government agencies, educational institutions, and professional associations that provide funding, staffing, and legitimation to the agency; and (4) the general environment, i.e., the "broad context" or sociological framework, within which the agency operates. Aspects of the general environment include demographic and economic circumstances, political conditions, legal mandates and constraints, treatment techniques, and such attitudinal considerations as the extent to which the community "is committed to caring for its impaired or impoverished members, or the extent of toleration of deviant behavior." (p. 74) Since problems accompanying deinstitutionalization may be generated in any of these environments, solutions must take all of them into consideration. Johnson's conceptualization is readily applicable to program planning for the other target populations of deinstitutionalization.

With a systems approach it is possible to analyze and confront some of the problems that are essentially overlooked by more molecular planning approaches. One such problem concerns the setting of priorities in service delivery. For the most severely disabled individuals to be provided with adequate care, they must be assigned top priority in the service system; conversely, when the most severely impaired clients, with their peculiar combination of service requirements, chronicity, and impotence, have to compete for scarce resources with others who are less severely impaired and more socially acceptable, they do not fare especially well. Yet, there is evidence in the history of the deinstitutionalization movement that the requirements of these individuals, in actual service settings, have in fact been subordinated to those of clients who are unhappy but essentially unimpaired. (Zusman and Lamb, 1977)

In summary, deinstitutionalization planning involves the formulation of complex public policy decisions and implementation strategies. There is now a need to translate our technology—which though still developing is substantial—into systems-related action. It will take some fundamental changes in attitude and funding practices to shift from the habit of looking at deinstitutionalization mechanistically toward a more comprehensive approach. But this objective must be realized if the global needs of the severely mentally disabled are to be met. For severely mentally disabled clients and for elderly and physically impaired clients, the successful deinstitutionalization program proceeds from concepts with clearly understood referents and from a precise statement of program goals. It is one in which there is a focused effort to fill in gaps in services. (James, 1978) And it is one that strives to meet the special needs of the disabled in all settings, those in institutions as well as those in the community.

Thiele and his associates (1977) eloquently express these considerations of humane deinstitutionalization programming: "The institutionalization process ... is deeply entrenched in the culture of caregiving systems. The purpose of programming for deinstitutionalization is not to stop institutionalization. It is, rather, to minimize the negative impact of institutions and institutional practices. Stated positively, deinstitutionalization is an attempt to revitalize the potential of service delivery systems for responding appropriately and efficiently to the needs of persons that those systems are established to serve."

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II. Sound, Targeted Compassion: Assessing the Needs of and Planning Services for Deinstitutionalized Clients

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Many of them are in extreme straits, as they fall through the cracks in the system of social agencies, institutions, and services. Some suffer the perpetual distress of incompetent compassion; most are rejected or feared by society. They are the deinstitutionalized clients; the formerly hospitalized mental patients; previously institutionalized developmentally disabled; previously hospitalized physically disabled; or formerly incarcerated. They are individuals who need to be assured that neither their personal histories nor past victimization will be compounded by the consequences of indifference, inflation, and/or belt tightening.

Responsive and adequate care is the assurance that deinstitutionalized clients need, and is the end goal. Assessing their needs is the beginning. Identifying and meeting the needs of deinstitutionalized clients who reside in the community involves sound, well-targeted compassion, in the form of needs assessment, planning and implementation. It involves the identification of *who* are the deinstitutionalized community residents of concern, *how many* are they, *where* are they within the general population, and *what* are their specific *service needs*. This paper will address the definitions of deinstitutionalized target groups, the methods and state of the art of assessing their needs, the related planning of services, and the relevant limitations.

Background

Deinstitutionalization, a social ideology and a political, public health policy phenomenon, has been in effect during the last 35 years. However, as noted by Whittington (1969), "Nowhere is the discrepancy between public and private morality, between verbal pronouncement and actual behavior more apparent than in the field of ... institutional aftercare." This sad state of affairs is probably the unintended offspring of benign neglect and an underdeveloped technology.

According to the U.S. Census, in 1950 there were 1,566,846 persons, about 1 percent of the total population, in institutions. In 1960, the number of people classified as inmates of institutions increased to 1,866,967, and in 1970 to 2,126,719. Institutional settings included correctional institutions, homes for the aged, mental hospitals, institutions for the mentally handicapped, homes for neglected and dependent children, facilities for juvenile delinquents, detention centers, institutions for the physically handicapped, and homes for unwed mothers.

The increase in the total institutional population, however, coincided with dramatic shifts in the relative population size in different types of institutions. Whereas mental patients consisted of 39 percent of all institutionalized persons in 1950, they made up 33 percent in 1960 and dropped to 20 percent in 1970. In comparison, the respective proportions of residents in homes for the aged were 19, 25, and 44 percent. (Kramer, 1977) Selected shifts in institutionalized populations were impacted by mandates and court rulings. A case in point is the 1978 court-ordered dispersion of a large State institution for the retarded in Pennsylvania. In that case, placement in community group homes was ordered for over 1,000 severely retarded. Thus, though some types of institutionalized populations increased, others decreased. Still other populations experienced rapid turn over, resulting in significant deinstitutionalized subpopulations being out placed in the community.

Population shifts (i.e., increased older as well as increased crime-prone populations), coupled with changing patterns of care of the physically handicapped, the retarded, and the mentally disabled, have resulted in a lack of definitive information about the scope of differentially disabled and differentially visible community subgroups. Having insufficient political strength and advocacy, deinstitutionalized persons tend to become invisible, only to reappear when tragedies, such as boarding home fires, strike.

The plight of deinstitutionalized persons has been described by the media and the professional literature, using the highly emotional arguments, pro and con, in which most public issues tend to be posited. The literature, abounding with attempts to document one point of view or another, was aptly reviewed by Bachrach (1976). Bachrach listed the conditions for desirable outcomes as, first, precise definition of deinstitutionalized populations; second, the identification of service needs; and third, the development of services and designation of responsibilities, all of which this section will address.

Identification and Definition of the Target Groups of Concern

Common to all deinstitutionalized clients is a history of:

- separation from one's natural environment and network;
- a duration of drastically decreased independence in which control and authority over one's life were delegated to a social institution;
- a return to the community;
- an assumption about a long-lasting condition resulting either from an intrinsic disability, from the impact of institutionalization, or both.

The precise definition of each deinstitutionalized client group has to be articulated, since it would vary with the reason that brought about the institutionalization. Thus, the target group of the physically handicapped will be differently defined from that of the mentally handicapped or from that of former prisoners. All three target groups share a history of separation from their natural environment and of institutionalization. The long-term disability of the physically handicapped, however, is easier to identify, define, and measure than that of former prisoners. Still, one can assume a need for services and reintegration for all deinstitutionalized persons.

Deinstitutionalized mentally disabled clients have been defined via the three d's: diagnosis, disability and duration, or "persons who suffer severe and persistent mental or emotional disorders that interfere with their functional capacities in relation to such primary aspects of daily life as self care, interpersonal relationships, and work or schooling .... " (Goldman, Gattozzi, and Taube, 1980). The authors suggest that target group delineation might be based on functional incapacity, i.e. impaired self-care, mobility, self-direction, capacity of independent living, or economic self-sufficiency. In contrast, it might be operationally defined as

recipients of SSI due to long-lasting disability. The easiest target group definition, of course, can be constructed as a simple function of having versus not having a history of institutionalization. The decision whether to broaden target group delineation by using multiple criteria is related to intent. For instance, interest in prevention should focus on all persons who are at high risk of future institutionalization rather than on those who have been institutionalized in the past.

General Facets of Need of the Deinstitutionalized

As with definition, delineation of the needs of the deinstitutionalized spans over several dimensions and is highly related to the nature of the target groups. The needs of the physically handicapped tend to be task related, e.g., the handling of daily activities, mobility, productivity/employment, or recreation; secondary disabilities of social and interpersonal difficulties may also follow as well. The formerly incarcerated might be subjected to social and employment difficulties. Deinstitutionalized developmentally and mentally disabled usually exhibit functional impairments in most of the areas of self-care, self-direction, interpersonal relationships, social integration, learning, and recreation. It should be noted that delineation of need is highly affected by prevailing views of needs in relation to service availability and effectiveness, all of which have a history of shifts and changes.

Finally, delineation of need that is conducive to planning of services is aided by augmenting information about disability and need with that of location. Comprehensive target group assessment is little more than the counting of people by categories of need and location of residence; that is, who the deinstitutionalized are—type and deficiency—and where they are.

Methods and Procedures of Need Assessment

Identifying service needs can be approached by individual assessment of every member of the group or via inferences made from population assessment. The former is akin to personal evaluation in clinical medicine, while the latter is parallel to population medicine and epidemiology.

Clinical medicine focuses largely on the medical care of sick individuals who present themselves for help. In population medicine, the community replaces the individual patient as the primary focus of concern. The intent of population medicine is to evaluate the health of a defined community, including those members who could benefit from, but do not seek, medical care. This epidemiological approach is related to an emphasis on identification of risk and on prevention. It is closely related as well to the conceptual shifts of the last 35 years, from a focus on biological and intrapersonal etiological dynamics to determinants of well-being located in the community and associated with interpersonal dynamics.

Assessing the need of deinstitutionalized clients can be accomplished by assessing the needs of persons identified as having a history of deinstitutionalization (which parallels the approach of clinical assessment) or by assessing populations, relating the prevalence of deinstitutionalized residents and population characteristics and inferring about needs from these data. Since the whereabouts of deinstitutionalized persons is usually not known and assessment of every household is not feasible, assessing the needs of deinstitutionalized people usually involves a combination of clinical and population assessments.

Need Assessment and the Process of Planning

Needs assessment is the first step in a four-step process of planning. It is a diagnostic and problem-identification activity that describes existing states and situations. The second step consists of forming conclusions about the desirable states and situations; where we should be

as compared with where we are now. The desired situations provide the identification of direction, goals, and objectives toward which future activities are to aim. Once the goals and objectives are identified, the third step consists of choices of means for reaching the goals and objectives. The fourth and last step is evaluative; assessment both of the methods and of goal attainment, as illustrated by the following example.

A followup of youth who were discharged from a detention center revealed that recidivists report having too much free time and "hanging around with other guys with nothing to do." Further examination led to the conclusion that youth discharged from detention centers need structured recreation and the support of peers who value staying out of trouble.

A program is designed and implemented, the goal of which is to provide "graduates" of detention centers with structured recreation and to create a positive support system. These goals are to be attained by establishing "a graduates club" which has available a facility for gathering as well as recreational activities and involvement. The evaluation of the program is accomplished via comparisions of recidivism among participants versus nonparticipants and of the costs of funding the program versus costs of services to recidivists.

Definition of Needs Assessment

Needs assessment is any activity which provides a description and/or measures of either the relative or the absolute needs of people living in a defined area for: (1) enhancement of a facet that is lacking in the residents' lives such as recreation; (2) specific services, interventions, or programs, such as teaching daily activities/living skills; or (3) the prevention of problems that will require interventions, e.g. prenatal care as means of reducing the incidence of physical, health, and emotional disorders due to problem gestation. The objective of needs assessment is to provide a typological definition and indications of magnitude of whatever aspect of life is being addressed.

Needs assessment studies might reveal that retirees are likely to suffer functional deterioration if they are lacking in social interaction and relationships; that is, it reveals an identified need for added or enhanced programs in these areas. Without such services many elderly might require placement in nursing homes. Or, needs assessment could address the degree of availability of counseling programs for truants, or of educational programs for parents which are designed to prevent truancy.

Needs assessment, as a set of coordinated activities, might also be characterized as a frail and weak offspring of evaluation and planning, which is both in vogue and in a struggle for survival. A prevailing requirement for most social and health programs, it has become the "in thing." However, ten references to needs assessment, once probed, are likely to describe 10 different activities. It is possible that the premature push for poorly understood technology and concepts has resulted in misuse.

The last 20 years witnessed a shift from the funding of social and health programs out of a philosophy of humanitarianism and abundance to a decisionmaking and allocation process bound by finite resources and a requirement for justification of expenditures. Where monies were previously provided freely, the present period sees an increasing emphasis on accountability. Caring for the disabled, previously assumed socially desirable and generously funded, now must be justified with cost-benefit data. Similarly, preventive programs, willingly funded in the past, now require documentation of impact. This is no less true with respect to services for deinstitutionalized clients, a fact that further strengthens the need for sound rationale and methodology in the needs assessment and services planning process.

The content of needs assessment may vary considerably even for the same target population. With respect to the education of the retarded, for example, assessment might address the need for infant stimulation programs, for adult education courses, or for vocational tracks in

public high schools. In public recreation, assessment could involve the need for outdoor recreational facilities, or for athletic programs for teenagers. In mental health, the purpose of needs assessment is usually to reveal the incidence and prevalence of mental disabilities in a total population and in potential risk groups within that population (e.g., the elderly). However, other mental health need assessments might involve early screening or prevention via consultation and education. In any of the above, community residents' lives may be examined in relation to the level of a desired facet (e.g., better education), the degree to which there is a lack of identified component (e.g., recreation), the magnitude of a problem (e.g., mental health disabilities), and the desirability/necessity of possible remedies (e.g., programs). In areas of health care, the purposes of social programs are to: (1) reduce the number and severity of existing disabilities; (2) maximize the proportion of residents free from problems and disabilities; (3) prevent the development of disabilities; and (4) prevent further deterioration of those who are disabled. Resulting health programs accordingly most usually consist of treatment, prevention, and rehabilitation.

Since there are no agreed-upon standards for an acceptable level of education or of available recreational facilities, assessments of need are often based either on comparisons with other similar communities or on the expressed views of residents. In such cases, the purpose of social programs could be to bring a community up to par with other similar communities or to respond to the expressed desires of potential consumers.

For the past decade or so, an increasing emphasis has been placed on the tenet that deployment of resources for health and social programs should be based on the needs of the community. Thus, Roen (1971) suggested that objective information of a community and its need and risk groups should be the basis for establishing priorities and program planning. As communities were entrusted with the responsibility for providing comprehensive services to those people residing within geographic service areas, data were needed to describe and detail local needs. However, emerging assessments of community needs varied. Some studies were traditional epidemiological examinations of the distributions of social, health, and mental disorders in a population and the variables associated with those distributions. (Mechanic, 1970) Bloom (1969) studied local needs through community surveys. Gruenberg (1969) elaborated on epidemiological methods (trends, age of onset, and risk), and associated factors.

In these efforts, a new problem emerged: the task of deciding what constitutes either a disorder or a socially unacceptable behavior. Examination of the interrelationships among demographic, environmental, and ecological variables on the one hand, and social and health needs on the other, are found in studies by Dunham and Faris (1939), Hollingshead and Redlich (1958), Srole, Langner, Michael, Opler, and Rennie (1962), and Redick and Goldsmith (1971). However, lack of clarity about definitions of "caseness" existed throughout. Consequently, numerous studies examined the rate of admission to institutions even at the time when most health and social service clients were served on an outpatient basis.

Nevertheless, increasing amounts of data supported the concept of studying the ecology of well-being and the relationships between the characteristics of a geographically defined area and the incidence and prevalence of problems among residents of that area. Those characteristics were found to be indirect measures and indicators of service needs. Blum (1974) described a two-step process of assessing community needs: (1) applying measurement tools to a defined social area, and (2) assessing, via judgment and inferences, the information obtained in order to determine priorities for planning and program development. Social area analysis, a methodology for derivation of indicators, assessing needs, and providing data for program development, emerged and has been gaining acceptance ever since.

Major Needs Assessment Methods

Needs assessment data identify and describe health and social disabilities in a defined community in order that service providers plan and improve programs. Needs assessment strategies range from direct to indirect measures and involve the eliciting of data from community residents and from service providers, and the making of inferences from available data. Needs assessment utilizes any one or a combination of four generic methods: (1) direct assessment of needs via an epidemiological, household survey, (2) tapping the perception of needs of either key community people or of community residents, (3) inferring needs from patterns of ongoing service utilization, and (4) inferring needs from known associations between social area characteristics and the prevalence of social and health problems.

Epidemiological Survey

The epidemiological survey is the most valid and comprehensive needs assessment approach. It can be designed to survey the total population, a specific age group (such as the elderly), or a population subgroup (such as residents of group homes). A sound epidemiological survey requires: (1) a good sampling procedure; (2) a well-designed and pretested interview schedule; and (3) trained, reliable interviewers who know the community, who will be trusted by residents, and who will adhere to sampling and predesignated procedures.

Epidemiology is the study of the distributions of states of ill health in defined populations and the corresponding distributions of variables that are associated with those states of ill health. The purpose is to learn about the etiology of the problems under study and be able to control them. The epidemiological survey instrument is intended to measure the presence and magnitude of a problem, such as the existence of a physical handicap, mental retardation, or an emotional disorder. It also aims to elicit sociodemographic data and any other information that is likely to be related to the problem of concern. Thus, if mental disorders are assumed to be related to poverty, marital status, and community cohesion, the interview schedule should include a measure of mental status and items that tap income and other sociodemographic characteristics, including marital status, and questions about the structure and organization of the community.

Data collected in epidemiological surveys can provide information about:

- problems of concern, their prevalence, degrees of severity, and the personal and environmental characteristics that tend to cooccur with these problems;
- individuals who are afflicted, and their service histories and needs;
- whether persons who need services utilize them, including their attitudes toward providers of services and perceptions of barriers to services; and
- the community, residents' attitudes, and residents' knowledge and understanding of social problems.

The community survey is most useful in establishing clear delineations of need, knowledge of what problems tend to cooccur, identification of problems of service accessibility, and understanding the role of attitudes.

Epidemiological surveys have several advantages:

- They can provide factual information about actual prevalence of problems and a firm base for both assessment of need and for planning of services.
- They enable the use of established instruments, coupled with options to modify instruments and procedures to meet local needs.
- They offer opportunities to assess the relationships among various problems and personal and community characteristics.

- They make it possible to test residents' familiarity with and attitudes toward service providers.

At the same time, there are some disadvantages and limitations, which include:

- The need for clear and rigorous definition of the problems of concern and of a potential "case;"
- The need for careful and sound sampling procedures;
- The need to include both attitudinal and behavioral measures; for example, inclusion of an assessment of the frequency and type of alcohol consumption, in addition to any requests for self-description of drinking habits;
- Care must be taken to avoid antagonizing residents who might consider the interview an invasion of privacy;
- Interviews may raise unrealistic expectations in the community;
- The design of a sound survey requires a great deal of expertise;
- In order to be representative, household surveys usually require interviews with a large number of residents and tend to be costly.

Conducting an epidemiological survey is a sequential procedure consisting of numerous subtasks. All needs assessment procedures require careful determinations of what information is needed and what resources are available for the actual assessment. Once an epidemiological survey is selected, the following tasks need to be carried out:

Step 1. Delineation of responsibilities; who will design the instrument, who will select and train interviewers, etc.

Step 2. Identification of data needs; what information is desired, what questions are to be answered by the survey, and what should be the corresponding sections of the interview schedule.

Step 3. Review of existing instruments; choice of suitable existing instruments or sections thereof, design of an instrument, solicitation of reactions, modification (as needed), and a pretest. Special attention must be paid to clarity of questions, and suitability of terms to be used with each study population.

Step 4. Design of sampling frames and procedures; sampling has to assure that findings will be both representative of the intended population and generalizable. If certain subgroups within the population are of concern (for example, the elderly or minority groups), the inclusion of a sufficient number of members of these groups need to be assured via the sampling procedures.

Step 5. Drawing the sample; the sample size has to be determined for each stratum of the population under study. Allowances have to be made, in the form of including additional cases, for an anticipated number of refusals to participate and/or being unavailable for interviewing. In addition, certain respondents will not be able to participate due to disabilities or language barriers. In all cases, procedures have to be detailed in advance, including the choice of an interviewee in each household.

Step 6. Preparation of training material and procedures for intended interviewers; this should include instructional material, strategies for gaining entry to homes, how to conduct oneself, how to handle objections, how to deal with evasions and how to probe, and other common difficulties. All these should be included, with detailed instructions, in an interviewer's manual.

Step 7. Selection and training of interviewers; interviewers should be presented with the training material and made very familiar with the instrument, to the point that reading the questions is easy and natural. Role playing of both easy and difficult interviews is a helpful training technique.

Step 8. Preparation of the community; though often overlooked, this step is crucial for assuring positive community response and cooperation. The aid of key community leaders

should be enlisted for the task of advertising the impending project and encouraging positive responses of residents via advertising and other public information methods. Interviewers can be provided with copies of newspaper articles about the project (pasted on cardboard) to be presented to household residents to facilitate entry into homes. Prominantly displayed identification tags are also likely to facilitate gaining entry to households.

Step 9. Data collection; field supervisors should assure that the interviewers follow all specified instructions and procedures, including the number of required callbacks on households where there have been no responses to prior calls. Additionally, there are several methods of verifying the collected data, such as brief mail or phone communications in which thanks are conveyed to respondents and a few inquiries made (e.g., when did the interview take place, how long did it last, etc.) to assure that interviewers submit truthful and accurate data.

Step 10. Data coding and editing; all completed interviews must be reviewed for data completion and interviewers notified when forms are not properly completed. Precoded data of completed interviews need to be either tabulated or directly entered into the computer data base. Further editing can be performed by computer, such as checks for contradictory answers.

Step 11. Data analysis; analysis of the collected data consists of: frequencies and descriptive statistics; predetermined analyses that have been designed to provide answers to the research questions; additional analyses, based on findings that emerge from the initial computer runs. It is important that the major analyses are designed before the survey instrument is finalized. This will assure the inclusion of needed items for the desired information.

Step 12. Sharing of findings and solicitation of feedback; data and findings should be presented to service providers, key community persons, and individuals knowledgeable about the field in question. Reactions and criticisms can be helpful in the design of further analyses and/or any modifications.

Step 13. Whenever possible, survey data should be integrated with additional relevant information—findings from other methods of need assessment, data on service utilization, and available service resources. This will enhance the reliability and quality of inferences.

Step 14. Final report; a report, consisting of the project description, summary of the data, inferences, and findings should be prepared and widely disseminated.

Key Informant Approach

Needs assessment by means of a survey of key informants is based on the assumption that certain individuals are in a good position to perceive the patterns of needs in the community. Thus, it is assumed that school personnel can generalize beyond daily experiences and particular classes and describe the prevailing needs of children. Similar assumptions may be made about other strategically placed community members, including policemen, social agency staff, ministers, health professionals, and community leaders.

The key informant method is generally simple and inexpensive. It provides for input from broad yet knowledgeable segments of the community and fosters relationships between the agency conducting the needs assessment and the community. As such, a key informant surely is desirable both by itself and in conjunction with other methods. Key informants, by virtue of their roles in the community, are in a position to identify the problems that are likely to become public issues, to indicate what actions are likely to elicit public support, and to lend their knowledge of the community.

The major advantages of the key informant method are:

- its ease and relative low cost;
- it enhances interaction with the community and becomes a form of public relations;

- it makes possible use of existing instruments and available staff;
- it provides for broad community input, including information about politically sensitive issues.

The main limitations and disadvantages of this approach include:

- Key informants may introduce biases toward the individuals or organizations that they either formally or informally represent. Thus, school personnel are likely to view problems of children as having the highest priorities, while workers with the elderly are likely to emphasize the elderly as a high priority target group, etc.
- By nature of the procedure, input is assured for population segments known to the key informants, while other community subgroups might be overlooked.
- Selection of the key informants to be utilized is made more or less arbitrarily, leading to the possibility that some bias might influence which informants are asked to participate.

Steps in conducting a key informant survey include the identification of intended respondents, the design of the instrument, and the specification of procedures. The following steps should be followed:

Step 1. Identification of key informants should start with agency personnel and provider staff who interact with the community. To assure broad community coverage, each identified key informant might be asked to name two additional participants for the survey, who in turn might be requested to name other people to be interviewed.

Step 2. Existing instruments, local data needs, and issues to be covered by the intended survey should be carefully reviewed.

Step 3. The key informant survey instrument should be designed and subjected to pilot testing.

Step 4. The procedures should be detailed. For example: interviews can be conducted face to face, or alternatively, the survey instrument can be mailed with a cover letter and a request for response. (A useful compromise is to mail the interview schedule with an explanation and indication that a phone call will follow in which answers will be requested.)

Step 5. The areas and populations of concerns should be identified, and questions formulated to elicit the needed data organized into the key informant survey instrument. Questions might inquire about high priority service needs, request identification of high risk groups, estimates of prevalence of problems, perceptions concerning attitudes toward services, and barriers to services. A draft instrument should be presented for reactions and suggestions before the final instrument is prepared. The intended framework for data analyses should be detailed at this stage, to assure that the final instrument and items provide the desired data.

Step 6. The next step is the selection of key informants. A master list of all such informants should be compiled, including each potential respondent's occupation, affiliation and constituencies, if any. A stratified random selection should be used to reduce the number of key informants to the desired size, while assuring the inclusion of all major categories, such as service providers, physicians, ministers, police, school personnel, etc.

Step 7. An announcement and explanation of the key informant survey should follow. A letter signed by a recognized and reputable person, i.e., a program administrator or agency director, should be mailed to all identified key informants, announcing and explaining the purpose of the project and requesting the respondent's cooperation.

Step 8. Data collection is next. Among the several procedures which can be employed are face-to-face interviews, mailed survey, or the recommended procedure, as follows: The survey instrument should be mailed several days after the announcement and explanation of the project. Three days after the mailing a phone call should be made either to elicit answers or set another time for the data collection. This provides respondents with time to review the material and with a mechanism to designate a more convenient time for the actual data collection.

Step 9. Finally, analysis and writeup should be performed. Analysis should consist of frequencies and descriptive statistics, predetermined analyses, and additional analyses based on initial findings. Results should be circulated for feedback before a report is prepared. The report should be widely disseminated, making sure that all key informants receive a copy.

Rates-Under-Treatment Approach

The most accurate predictions of future service utilization are based on trends derived from patterns of past utilization. Examination of who are the service utilizers (in terms of sociodemographic characteristics), identification of their respective problems, and the duration of services received can help refine predictions by generalizing to populations of concern.

The main advantages of rates-under-treatment is that it capitalizes on existing information and does not require further data collection. It is also quite easy and straightforward to execute.

The major drawback of the rates-under-treatment method involves the discrepancies between true population needs and prior service utilization patterns. Due to barriers to services, lack of information, and lack of appropriate prior program, frequently differences exist between need and utilization, referred to as unmet need. Since rates-under-treatment addresses only utilization, it does not provide for identification of unmet need.

Social Area Analysis and Social Indicators

The most indirect method of needs assessment is based on inferences drawn from known associations between social and environmental characteristics and the prevalence of health and/or social problems of concern. The objective of social area analysis is to discover sets of observed variables that display nontrivial patterns of correlations with criteria. These are empirically discovered regularities and are used to predict health and social problem occurrence. Although social indicators are sometimes related to etiological determinants of the problems under study, the state of the art suggests that they be viewed as associated "symptoms," rather than as indicative of a cause and effect relationship.

A major advantage of social area analysis as a method for conducting needs assessment is its utilization of available data, e.g., U.S. Census data or indicators available in the Mental Health Demographic Profile System. (MHDPS, HEW 1976) The limitation of using social indicators in needs assessment is twofold. The method is most indirect and inferential, and the generalized associations between indicators and problem prevalence do not account for specific differences among localities.

The steps to be taken in needs assessment based on social indicators can vary in depth and sophistication. The basic procedure includes the identification of a few recognized indicators that are consistently related to social and health problems, e.g. socioeconomic status, social cohesion, family disruption, and the like; second, the compilation of indicator data per real unit: that is, the percentage of families in poverty, the percentage in broken homes, etc. per service area; third, the ranking of service areas according to their respective indicators data; fourth, the combining of all ranks to create average ranks that are based on several indicators as a means for prioritized needs.

Comparison of the Four Major Types of Needs Assessment Procedures

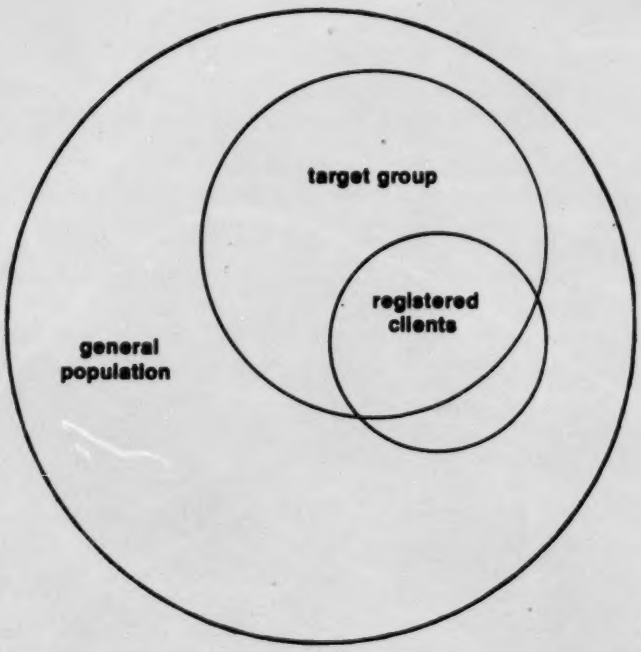
There is no single definitive method of needs assessment. Each of the four procedures described above has advantages and disadvantages and is more applicable in some situations than in others. The community survey is most direct and probably most valid, but it is also

complex, extensive, and expensive. The key informant survey provides for important input and is easy, quick, and inexpensive. It is likely, however, to be biased. Rates-under-treatment utilizes existing data for generalization from service utilization to expected further utilization patterns. It is weak, however, in addressing and assessing unmet needs. The use of social indicators requires existing data and no data collection. It is indirect and inferential, but lends itself to quantitative manipulations and analytical procedures that range from the simple to the sophisticated.

Needs Assessment Issues and Deinstitutionalized Clients

Needs should be assessed for defined populations. In some situations, information being sought concerns the social service needs of all residents within a service area; that is, total population need assessment. In others, since prevalence of health and social problems varies from one population subgroup to another, assessment might aim at identifying the needs of high-risk subpopulations only, or for any other clearly identified subpopulation or target group, which might include particular age groups (the elderly, children, etc.), or a group defined by selected sociodemographic characteristics (children in broken homes, the deinstitutionalized). The smallest group for whom assessment of needs may be undertaken is the registered clients. These groups overlap with each other as can be seen in Figure 2-1.

Figure 2-1.



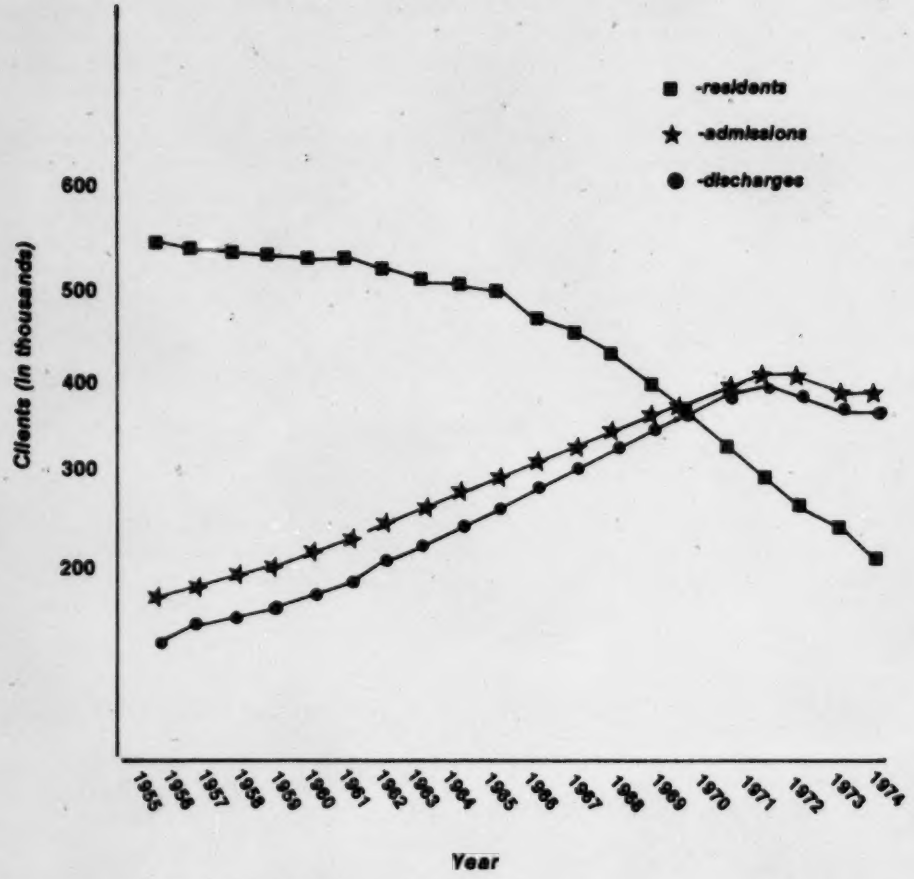
Assessing the needs of registered clients is easiest because, by definition, registration consists of a complete enumeration of group members. Assessing the needs of all community residents can be accomplished by sampling of households. Needs assessment of a population subgroup, such as the elderly, is more complex because households are not identified by the age of residents and numerous doorbells need to be rung before a suitable interviewee is found, a difficulty that has to be made up for in the sampling procedure. Identifying the needs of deinstitutionalized persons is most difficult, for two reasons: 1) The prevalence of deinstitutionalized persons in the community is low, making it difficult to find them by means of a random survey, and 2) the visibility of deinstitutionalized clients, who tend to "disappear into the woodwork," is also low. The rates-under-treatment method for assessing needs of deinstitutionalized clients is ineffective because, either due to disabilities or to low level of functioning, a discrepancy usually exists between the needs and service utilization of the formerly institutionalized.

Various governmental agencies compile statistics relevant to deinstitutionalized groups. Using the U.S. Census and data compiled by NIMH, the National Nursing Home Survey, the National Center for Health Statistics, and the Social Security Administration, Goldman, Gattozzi, and Taube (1981) have estimated the number of the chronically mentally ill (mostly deinstitutionalized mental health clients) in the community to be between 800,000 and 1,500,000 in the late 1970's; that is between .38 and .71 percent of the total population.

Kramer (1977) gathered information on all institutionalized persons in the United States. From 1950 through 1970, institutional inmates made up about 1 percent of the total U.S. population. However, changing compositions of institutionalized populations (increased proportions of elderly in homes for the aged versus decreased proportions of the mentally ill; the rapid turnover in homes for neglected children, unwed mothers, and correctional institutions; and recent emphasis on normalization and shifts in focus of care of retarded and of physically handicapped in the community) suggest that many previously institutionalized persons currently live in the community.

The trends of annual numbers of residents, admissions, and discharges of institutional mentally ill persons between the years of 1955 and 1974 (based on Kramer 1977) are shown in Figure 2-2. The data indicate annual discharges of close to 400,000 former mental hospital patients. In comparison, Goldman, et.al. (1981) estimated the number of annual deinstitutionalized persons to be 650,000; approximately 160,000 who return to live with their families and the rest to the community at large.

Figure 2-2. Annual Numbers of Residents, Admissions and Discharges of Institutional Mentally Ill Clients Between the Years 1955-1974



Source: Kramer, 1977

Selected Methods for Assessing the Needs of the Deinstitutionalized

Need assessment technology is not yet fully developed. Available data are limited and often incomplete. Extensive data collection presents its own restraints and is beyond the scope of most projects. The relatively low base rate (or proportion in the population) of deinstitutionalized clients further hinders locating the appropriate individuals and provide for their needs. Consequently, an eclectic combination of procedures is to provide optimal means for the desired needs assessment and planning.

Disabled persons by reasons of physical, developmental, and psychosocial disabilities are entitled to various fiscal, health, and social service benefits. Since all these services, including assessment of eligibility and service accountability, require record keeping, resulting data can provide valuable information about the number of persons with persisting health and social problems, their sociodemographic characteristics and their area of residence. Of these services, the most suitable for assessing the needs of deinstitutionalized clients are records of medicaid, medicare, Social Security Disability benefits (SSD), Supplemental Security Income (SSI), vocational rehabilitation and Title XX services.

Aggregate figures about long-term, work-disabled persons could be derived from SSD and SSI records and obtained from the Social Security Administration. Since discrete counts of specific disabilities are not available, the total number of recipients can be multiplied by the proportion of the target group of interest to total recipients in order to estimate the group size of the target population in question. Thus, if the developmentally disabled make up two-thirds of SSI recipients and a particular area has 3,000 such recipients, then 1,000 developmentally disabled can be expected to reside in that area. The same procedure can be employed for the mentally disordered, physically handicapped, etc.

Similar sources of information are provided by medicaid and medicare. Contingent on appropriate local record keeping, pharmaceutical records of prescription of medications which are unique to specific disabilities can augment the information. These, though, are rarely sufficient when considered alone.

Good records are maintained by State and national vocational rehabilitation agencies. Recipients are classified by disabilities, type of needed rehabilitative services, and outcome. The quality of the data are the main advantages of this source. Its main limitation is the fact that neither clients receiving nor applying for vocational rehabilitation represent the total group of persons needing the service.

A final source of information about services provided to groups that might include deinstitutionalized clients is the information compiled by service providers funded by title XX. Although title XX is a Federal funding source, different States have implemented varying information systems. Nevertheless, most records contain information on disabilities and service history. Since eligibility is largely determined by financial need, rather than disability, additional assessment should ascertain the proportions of the different deinstitutionalized clients among both applicants and recipients.

Integration of Information and Suggested Procedures

Based on the review of (1) the situations and status of deinstitutionalized clients, (2) common methods of needs assessment, and (3) constraints and unique informational sources concerning deinstitutionalized persons, the following needs assessment activities and data integration are recommended.

In order to obtain estimates of the *size* of the deinstitutionalized client group of concern, five sources of information are likely to be helpful. First, national reports and estimations produced by relevant governmental agencies—NIMH for mental health clients, LEAA for the formerly incarcerated, etc.—may be used as rough boundary estimates for average populations. Many of these agencies produce low and high estimates within which actual group sizes are likely to be found. Second, service entitlement and health care records such as SSD, SSI, and medicaid provide information. However, these sources may provide low estimates (because some eligible persons do not avail themselves of services) by States, and often by municipality, and therefore can be used to establish "floor" or lower limits. Third, inclusion of social area indicators known to be associated with the prevalence of problems of concern can

be added to differentiate among small areas. Thus, if the number of deinstitutionalized persons in a particular town is estimated as 500, and the town has known areas of concentration of such persons, then most of the target group individuals are likely to reside in those areas. Census-derived data of "percent living alone," and "percent living in group homes" are instances of such indicators. Fourth, data collected from service providers and community agencies and organizations as part of a key informant survey can further refine estimates of numbers and locations of deinstitutionalized clients. Fifth, boarding homes licensing and enumeration, which is being implemented by an increasing number of States, provide information. Records of licensed boarding homes can be used both for estimating the number of deinstitutionalized clients (who typically are the majority in such residences) and as sampling frames for accessing individuals for interviews.

Assessment of the characteristics of the group of concern can be derived from two sources. Key informants provide data descriptive of the target group. Surveys of deinstitutionalized persons can provide descriptive information to be generalized to similar persons. These can be either registered clients who are known to the service system or boarding home residents, identified through licensing records.

Assessment of *service needs* can either be inferred from the type and severity of disabilities of the target group or directly measured by means of the following three procedures. First, detailed assessment of institutionalized clients who are scheduled for discharge can be performed: their characteristics, type, and severity of problems; the corresponding services designed to ameliorate or reduce the problems; and generalizations of findings to deinstitutionalized persons. Numerous States and different types of institutions have developed such assessment documents. An example is the Systematic Treatment and Evaluation Procedure used at the Norristown State Hospital in Pennsylvania. Second, detailed assessment of deinstitutionalized persons who are registered for or receiving aftercare services can be utilized for generalization of findings to all deinstitutionalized persons. The Service Utilization and Need (SUN) document by Jon Muller at the Alabama Department of Mental Health is an example, although numerous others have been developed. Third, a key informant survey of service providers, related community agencies, and, if possible, relatives of deinstitutionalized persons can provide additional data and perspectives about service needs of deinstitutionalized clients.

The planning of service programs should begin with an assessment of available resources, ongoing programs, the degree of development of existing systems, and potential barriers to services. Available resources can be ascertained via: government listings of programs; records of funding and allocations; data collected from service providers and key informants; and information derived from patterns of service utilization.

Both available resources and service utilization are measures of the extent of service system development and should be integrated into these data. Comparisons of available programs and service utilization can reveal barriers to services. For example, high need identified in a location in which there are appropriate service programs yet low service utilization usually indicates barriers to services and accessibility problems. Barriers could result from lack of awareness, misunderstanding disabilities, lack of trust in the value of services, problems of mobility or unavailability of transportation, and culturally rooted negative attitudes. Indications of inaccessibility should be followed with a probe into the nature of the barriers and a determination of appropriate interventions.

Data dealing with assessment of unmet need and of needed funding should be integrated. An identified service need coupled with an absence of a program to meet the need represents a gap, an "unmet need." High need, coupled with insufficient programs, documented low level of resources, and/or waiting lists, indicate that either additional services or improved effi-

ciency of existing programs are called for. Relating needs assessment findings to funding is a complex task because it requires comparisons across two types of data—need and available programs—and inferences about a third—allocations.

Three different procedures can be utilized in integrating these divergent data. The simplest and least informative is data integration via ranks. Areas can be independently ranked on (1) assessed need,(2) assessed amount of available resources, and(3) service utilization. Service utilization should be compared with available resources to check on possible barriers to services, and then the two can be averaged to produce a rank of system development. Assuming that high need indicates high priority for funding, the obtained rank can be used for categorizing areas in terms of priority for allocations. The main advantage of this procedure is its simplicity. Its limitation concerns its ordinal nature. Conclusions can suggest higher and lower priorities but not the extent of the differences.

A second method focuses on the translation of assessed need into required funding, which involves 5 steps: (1) ascertaining the number of persons with unmet need in each area; (2) detailing the unmet need in terms of specific services within residential and ambulatory service settings; (3) estimating the number of units of service to be required for an average recipient; (4) inserting the cost of each relevant unit of service; (5) calculating expected needed funds per area. It should be noted that limited funds may prevent meeting the total needs. This procedure, however, might provide for allocations that are proportional to assessed local needs.

The third procedure avoids the need to determine the exact number of people with unmet need yet, using somewhat sophisticated statistics, provides for equitable division of available funds according to assessed need. The first step is to ascertain need via either a direct method (number of people needing services, as reflected by SSI), or an indirect method (data derived from social area analysis), and transform assessed needs of all service areas to standardized scores. Second, available resources must be ascertained: available beds, full-time equivalent service staff, or available funds. Any or all three are to be transformed into standardized scores. If more than one type of available resource is used, standardized scores allows averaging of the data. Third, data on service utilization should be compiled. These can be in terms of total numbers, and in terms of weighted (e.g., inpatient having higher weight than outpatient services) or unweighted services. All compiled data should be transformed into standardized scores. Fourth, compare and contrast data on need, available resources and service utilization for each service area in order to reveal possible barriers to services. Fifth, integrate the three types of data. Sixth, apply the final, standardized need scores to available funds in order to derive the proportion of the total funds to be allocated to each area, i.e.,

$$\frac{\text{area score}}{\text{total score}} \times \text{available funds} = \text{funds to be allocated to that area}$$

A final consideration with respect to expenditures is to be given to start-up, as compared with operational costs. This is especially relevant to costs for residential services for deinstitutionalized persons, such as security deposits on rentals, equipment, furnishing, and staff training.

Summary

The present paper addressed the assessment of needs and planning for services for deinstitutionalized clients. Touching upon general notions of the difficulties experienced by deinstitutionalized persons, a review was provided of the background, scope and problems of identification, and description and assessments of interest.

Needs assessment was defined and its major approaches were described, including procedural steps, advantages, and disadvantages of the various methods. Utility for planning was discussed. Limitations of needs assessment methodology in general and difficulties unique to assessing the needs of deinstitutionalized clients in specific were noted and discussed. Sources for relevant data and examples of useful instruments were cited and briefly described.

Recommendations were made in terms of a relevant procedural sequence of steps and potential applications. These included assessment of size and description of target group, ascertainment of needed services, estimation of costs of needed services, and a procedure for delineating need-based allocations.

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III. Funding Sources for Deinstitutionalization Services

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Introduction

Although the concept and process of deinstitutionalization have been advancing for over 25 years, the funding patterns required to implement this system of care have been slow to develop. (Baron and Rutman, 1980; National Institute of Mental Health, 1978) This chapter will focus on the types of funding both required and available for deinstitutionalization programs and the various funding patterns that may be utilized.

Until quite recently, funding for the community care of the aged and disabled came primarily from private philanthropy. (Paul, et al., 1977; Rubin, 1980) Government programs at local, State, and Federal levels provided little by way of significant resources for community care, but rather focused almost entirely on the development and maintenance of various kinds of "asylums" including county homes, State psychiatric hospitals, and State schools for the mentally retarded. It is important to remember that institutional care was not only encouraged by prevailing funding patterns, but also by a service ideology which viewed institutions of various types as the most cost-beneficial and humane system of care. Over the past three decades, this ideology of care has substantially changed. (Scull, 1980; Tabor, 1980)

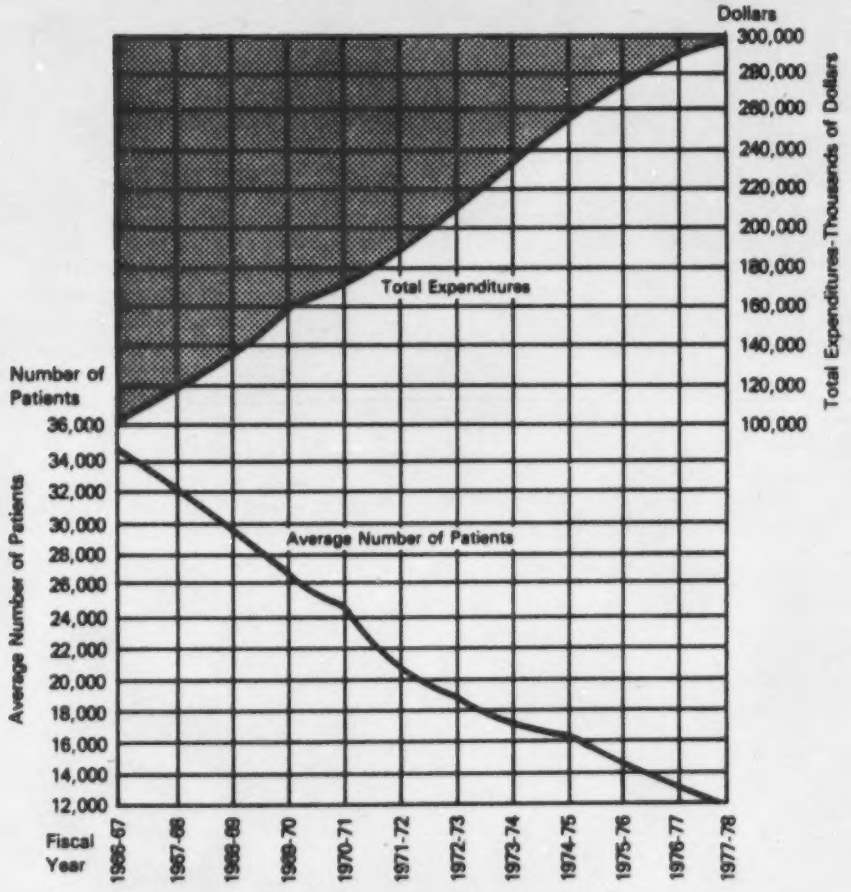
Current policies and perspectives toward deinstitutionalization are described in other chapters of this monograph. Although the professional ideology has changed, government funding sources have been slow to follow this change.(Ashbaugh and Bradley, 1979; Comptroller General of the U.S., 1977) While it is true that some new sources of funding have been developed in the last 10-20 years (e.g., Title XX of the Social Security Act), most observers would agree that the primary structure of funding with respect to community-based care has not substantially shifted correspondingly. For example, a recent survey of State Mental Health Authorities reveals that although patient populations have dramatically declined over the past 15 years, often by as much as 200 to 300 percent, State governments still spend about two-thirds of their funds to support State psychiatric hospitals rather than community care of the mentally ill. (Ashbaugh and Bradley, 1979; Comptroller General of the United States, 1977; Epstein, 1978) At the Federal level, the same inequities tend to persist. Similarly, despite the fact that medicaid (title XIX) funds can be used for noninstitutional care, the great bulk of these dollars are spent for nursing homes, general hospitals, and State facilities for the mentally retarded. This occurs because Federal law and regulations mandate these services and require them to be cost reimbursed. (Comptroller General of the United States, 1977; Horizon House Institute, 1978)

The reason for the disjunction between the professional ideology of deinstitutionalization and State and Federal funding patterns is complicated and exacerbated by many variations at State and Federal levels. However, there appear to be two primary issues involved. The first is that there is a confusing array of funding sources at all levels of government. There are separate programs for housing, for medical services, for social services, for income maintenance, for vocational rehabilitation. There are, in fact, literally scores of Federal programs which provide funds to support partially or comprehensively, one or another aspect of the deinstitutionalized individual's personal, medical, social, or vocational adjustment in society. These programs are administered at Federal, State, and local levels. The recent Comptroller General's report on returning the disabled to the community details —and deplores—the confusion at the Federal level in funding sources for the deinstitutionalization of various disabled groups. (Comptroller General of the United States, 1977) This same confusion and discontinuity of funding exists at State and local levels of government as well as for disabled populations. (Department of Health and Human Services, 1980)

The second reason for the lack of clear and adequate funding for deinstitutionalization has been the tremendous increase in the costs of institutional care. For example, in 1960 the cost of inpatient care in a State mental hospital averaged $15 per day. By 1979, this cost had risen to $85 per day. (Kane and Kane, 1980; Redick, 1974) Despite the decrease in institutional populations nationally, the actual costs of operating institutions is higher than ever. This increase has occurred for four reasons: the altruistic attempts of government—spurred by professionals and advocates—to provide decent, humane care in the institution; the substantial growth in salary and benefits of institutional employees as a function of the unionization of public employees; the impact of standards of care promulgated by national accrediting and certifying agencies; and court decisions which have mandated increased levels of care for institutionalized groups. (Task Panel on Deinstitutionalization, Rehabilitation and Long-Term Care Report, 1978) This enormous growth in the costs of institutions has made the struggle to fund reasonable programs for deinstitutionalized disabled populations all the more difficult. (Bisogno, et al., 1980)

The increase in institutional costs and decrease in clients is illustrated in Figure 3-1 which shows a comparison of community and hospital funding and clients for Pennsylvania's public mental health system.

Figure 3-1. Commonwealth of Pennsylvania
Institutions for Mentally Ill
Average Number of Patients and Expenditures
Fiscal Year 1966-67 through 1977-78



Institutional versus Community Care

From the inception of the deinstitutionalization movement there have been arguments and counter arguments about the relative costs of institutional and community care. These have been sometimes technical, sometimes political, and sometimes ideological in nature. (Sharfstein,1980)Advocates of deinstitutionalization have claimed that community care is significantly less costly than institutional care; unions, politicians, and some community groups have argued that community-based service costs are only a fraction of the real costs to the community, which must in addition provide increased public services. Research on the questions is lacking, but in general, evaluations tend to suggest that community care is less costly and more effective for some clients than institutional care. On the other hand, 15 years into the phenomenon of deinstitutionalization, it is clear that some severely disabled clients will always require an institutional setting, if an institution is defined as a place which produces total life support to disabled clients.

Basically, the question is: what clients are best served in the community? The determination of the cost effectiveness of deinstitutionalization should therefore not be an either/or issue, but rather a question of matching the level of client functioning to the level of service required. Some States and local service providers have begun to examine the problem from this perspective, but significantly more data are needed. In many places the question of institutional versus community care is a moot point. Since clients have already been discharged and courts have ruled that they must be permitted to remain in the community, the key question must be how to care for them in the community, not if.

Services Required for Deinstitutionalization

The deinstitutionalization of clients both consists of and requires much more than a discharge from an institution to the "community." In many cases over the last 20 years, disabled clients have been discharged to the "street" and to living situations that were grossly inadequate to meet their basic needs. On the other hand, institutions by their very nature were designed as total life support programs for clients. They provided not only health, educational, and other personal services, but all the life supports required by their residents such as housing, food, and clothing. In designing a program to deinstitutionalize clients, the same combination of life support and personal services need to be combined. As detailed elsewhere in this monograph, successful deinstitutionalization requires an appropriate mix of services. This includes the same ingredients we all need to survive independently as well as the specialized services required by the disability, e.g., personal income for food, clothing, and other necessities, housing and medical care, social services, advocacy, and service coordination.

Institutions have been traditionally funded by one or two funding streams and have provided a total life environment for clients. As previously noted, a primary problem with securing funding for deinstitutionalization programs is fragmentation and the multiplicity of funding sources. The basic services required by clients in the community can be categorized as housing, personal maintenance, medical care, social services, rehabilitation, socialization, and recreation. (Budson, 1976; Budson, 1979) Each of these services may be funded by one or more Federal, State, and local funding source.

Multisource Funding

Disabled clients who are deinstitutionalized will generally be supported by separate funding sources for every major type of service they receive. Thus, a client may secure personal maintenance through Social Security Disability payments, receive social services from an agency receiving title XX funds, and obtain medical services from an agency reimbursed by medicare and medicaid.

It is therefore essential that the planning and implementation of deinstitutionalization of disabled clients be based on a multisource funding model. (Smull, 1980) Multisource funding is a concept which is quite common in public programs of many types and means simply that programs are supported not by a single funding resource but by various funding streams for different services. Considerable questions have been raised regarding the cost effectiveness of such an approach in the operation of medical and social programs. Critics claim that it substantially increases the administrative costs of the services and periodically efforts have been made at the Federal and State levels to simplify and consolidate funding streams so that these costs can be reduced. (Ryan, 1979) Currently, however, the prevailing structure of funding for the disabled makes a well-designed multisource system a requirement.

Designing a multisource system for the funding of deinstitutionalization is a complicated process. At a State or local level it requires: 1) the identification of the services needed by the disabled client group; 2) identification of the funding streams available for the services; 3) an evaluation of the potential of each of these streams; 4) an evaluation of the stability of each of the funding streams; and 5) a program designed to capture enough of these resources to mount a service with some reasonable chance of success. This last factor, program design, is perhaps the most critical issue. In many cases the resources for adequate services to deinstitutionalized clients exist but have never been "packaged" as a multisource system in such a way to create the program. Designing programs to meet the requirements of funding streams is anathema to many planners and service providers. Either they believe their professional ideology of care should be funded on its merits, or they are concerned that modifying program design to meet the requirements of funding streams is somehow unethical. It should be noted, therefore, that most resources for funding are quite flexible and that ideological disagreements about deinstitutionalization are often more semantic than substantive.

Funding Resources for Deinstitutionalization

The following are some major streams currently available to disabled clients and to agencies providing services to deinstitutionalized populations. As previously noted, many of these services vary in accessibility and level in different states and local areas. This inventory is not exhaustive but is offered as a guide to those that are most frequently used. See attached Chart 3-1.

Client Cash Income Programs

Supplemental Security Income (SSI) for the aged, blind, and disabled was created in 1973 to provide a minimum level of cash assistance to individuals who are disabled. It is a Federal program for all disabled persons who meet uniform income eligibility requirements. For clients to be eligible, they must meet both income and disability requirements. This program pays clients directly (depending on living arrangements and other income) up to $238 per month. Most disabled clients who are deinstitutionalized are eligible for SSI; however, eligibility determinations vary from area to area and advocacy is often necessary for disabled clients to receive full payment. Payments under SSI may be made directly to the client, or in those cases where appropriate, to a representative payee who may be an agency or person. There are several variations of SSI payments that are possible, partly as a function of the Social Security Disability Amendments of 1980. Basically these amendments permit persons on SSI to keep some earned income without losing disability payments. SSI is complicated but does provide a basic level of support for all disabled clients. (Department of Health and Human Services, 1980.

Although SSI provides a minimum level of support for the disabled client, most States provide some funds to supplement the Federal SSI payments. This supplementation varies widely from State to State. Some States have specific requirements that must be met before client income will be supplemented, e.g., the client must be in foster care setting. In general, these programs were devised with the view that supplementation was less costly than keeping or returning clients to institutions.

General assistance which is known by various names from State to State (e.g., welfare, public assistance, etc.), involves cash payments made to clients on the basis of need and income requirements only, with no consideration or disability status as occurs with SSI. Monthly payments vary considerably from State to State.

The food stamp program, which is administered by the Social Security Administration and the U.S. Department of Agriculture, is designed to supplement client cash income. The

program is based on income level (not disability), and provides clients the opportunity to purchase food stamps which can then be spent in commercial grocery stores for food. It is essentially a client income supplementation program. Food stamps were recently made available to residents in group living situations.

Federal Housing Assistance Programs

Community development block grants are funds allotted to city, county, and other local government entities which are to be used for the acquisition, construction, and rehabilitation of facilities, parks, recreation facilities, and senior centers for the handicapped. These funds are distributed by local authorities on the basis of a plan submitted annually to the Department of Housing and Urban Development. Although these funds cannot be used for the creation of residential facilities for clients, they can and are used for the development of day treatment centers, renovation of vocational facilities, and other purposes. All communities which receive community development block grants must also submit a Local Housing Assistance Plan in order to be eligible for all other types of Federal housing assistance. In this plan, the local government must specify the local housing needs for elderly and handicapped persons in the community. Although this plan does not directly provide funds, it provides the priorities which determine other types of Federal housing assistance (U.S. Department of Housing and Urban Development 1968).

The housing assistance payments program, commonly known as the HUD section 8 rent subsidy program, is actually titled the section 8 housing assistance payment program. (U.S. Department of Housing and Urban Development, 1976) All section 8 programs have specific eligibility requirements: either the client must be disabled, or handicapped, or have an income low enough to qualify. Most clients with a history of institutionalization should qualify for this program. Basically, section 8 subsidizes client payments for rental housing. Eligible clients are expected to pay 25 percent of their annual income for rent and the section 8 subsidy pays the balance of the rent up to the "fair market rental value." There are "existing 8" subsidies available from local housing authorities at a city, county, or State level which can be assigned to clients. There is usually considerable competition for these funds and careful planning often is required to access them. "Existing 8" subsidies can be used by the client for housing in any building meeting HUD requirements.

Most section 8 subsidies are not assigned to clients under the "existing 8" program, but are attached to buildings—constructed, renovated, or financed by HUD under one of its mortgage programs. Under these programs the housing unit itself is assigned the section 8 subsidy and only eligible clients can live in these units. Access to such projects by disabled populations is possible and, for some projects, encouraged.

Many government entities operate traditional or local public housing projects. Clients are eligible for these projects when they meet general income limitations similar to the limitations under the section 8 program. Although most of these projects were developed for low-income families, Federal law prohibits discrimination against the handicapped and many disabled clients are eligible for placement into one of these projects. The Federal Government support for these projects is to the housing authority for the management and maintenance of the projects.

The HUD section 202 program for the elderly and handicapped provides direct or indirect financing (mortgages) for the construction or rehabilitation of housing for these populations. Under this program, HUD provides mortgages at far below market rates for private nonprofit agencies to create suitable housing for elderly and handicapped people. (U.S. Department of Housing and Urban Development, 1976) After section 202 funds have been committed, an application for section 8 assistance can also be submitted. Most 202 projects have section 8 payments assigned to all units. Although most of these funds have generally been used for the construction of high-rise buildings for the elderly, HUD has financed projects for the disabled,

and for the past three years has sponsored a demonstration program for housing targeted to the deinstitutionalization of the chronically mentally ill. Funding under section 202 is a stable and reasonable mechanism to promote deinstitutionalization. It is, however, a complicated and lengthy process requiring substantial housing experience and expertise.

The farmers home loan administration program is available in rural areas. It is a variant of the section 202 process. There are no specific restrictions regarding the use of this program for disabled clients. Most projects under this mechanism also have section 8 subsidies available for clients. (Department of Health and Human Services, 1980)

Many States have State housing authorities which provide and administer various housing assistance programs. In general, State housing authorities offer financing for the construction and rehabilitation of buildings which operate similarly to HUD programs, and which often provide rent subsidies for these projects. Although most have not been involved in housing for the disabled, they frequently have significant amounts of funding available and have shown positive interest in the housing needs of the disabled.

Funding for Services - Federal and State

Medicare, which was enacted in 1965, is a National program of health insurance protection for the aged (over 65) and disabled. Medicare consists of two separate but coordinated programs: hospital insurance and supplementary medical insurance. Hospital insurance (HI) pays for part of the costs of inpatient hospital care and the costs of services provided by skilled nursing facilities (SNF's). For both these services, the recipient must pay a deductible amount before medicare pays the rest. All people eligible for medicare hospital insurance are also eligible to purchase supplementary medical insurance (SMI) by paying a small monthly premium. Supplementary medical insurance pays 80 percent of all medical and health-related costs after a yearly deductible is reached. There are numerous restrictions on benefits and recipients must pay the SMI premiums and deductibles for all services. Client eligibility is determined on the basis of age or disability during the usual SSI disability determination process and funds are administered by the Federal Government. (In many States, medicaid funds are used to pay the deductible and supplemental medical insurance premiums for disabled clients with low incomes). Medicare has some significant limits, particularly for psychiatric care. For disabled clients (not aged), there is a 2-year waiting period before clients are eligible for medicare benefits; that is, clients must be on SSI for 24 months before they are medicare eligible. In many cases, those clients will be covered by State medicaid programs. (Department of Health and Human Services, 1980)

Congress enacted title XIX of the Social Security Act, usually referred to as medicaid, to furnish States with matching Federal funds to provide basic medical services to the aged, disabled and needy. Medicaid programs are administered by the State under Federal guidelines and regulations. Each State has its own regulations for client eligibility, payment provisions, reimbursable services, and administration of the program. States are reimbursed by the Federal Government for a percentage of their expenditures under title XIX. This percentage is based on the per capita income of the State.

Medicaid varies a great deal from State to State. In general, each State must pay for inpatient care in general hospitals, for nursing home care, for fees to physicians, for drugs and medications, and for clinic services in hospitals. The medicaid law also permits for the payment of a wide range of optional services covering other health care and rehabilitation services. (Department of Health and Human Services, 1980) Examples include psychiatric day treatment, prosthetic devices, and dental care. Although these services are permitted, each State has designed its own list of reimburseable services and uses varying income eligibility requirements for clients. A State-by-State review is required to determine the applicability of medicaid to each deinstitutionalization program.

Title XX is a Federal/State grant-in-aid program for social services under which States are allocated a fixed amount of funding (ceiling) on a 75 percent Federal, 25 percent State match basis. Title XX, in contrast to many Federal programs, places primary responsibility for administration of the services and funds on State government. There are stated Federal goals which include maintenance of economic self-support, maintenance of self-sufficiency, preventing abuse or neglect of children and adults, reducing inappropriate institutional care, and securing information and referral of clients. Within these goals and objectives, States have chosen to provide a wide-ranging array of services. There are currently over 1,200 different service titles listed in States' title XX plans, extending from information and referral to homemaker services. Although there is a maximum income eligibility limit set by Federal law, most States utilize their own client eligibility requirements. In many cases, States require clients to pay some portion of the services funded by title XX. Each State must prepare an extensive title XX plan each year for public review. It is through this plan that funds are distributed to various disability groups, services types, and geographic areas.

In 1963, Congress passed the Community Mental Health Centers Act (Public Law 94-63) which was designed to create a national network of locally based, community-related mental health services. These centers are mandated to provide a variety of mental health services to all in need, regardless of ability to pay. Centers are required by recent amendments in the law and regulations to focus services on the mentally ill who had been institutionalized. Specifically, centers must provide short-term inpatient care services, outpatient services, day treatment, court screening, consultation and education, specialized services to children and the elderly, services for drug and alcohol related disorders, and transitional living services. The facilities are funded on a deficit basis by the Federal Government in the form of direct grants to the agency; each center must serve all people in a defined geographic area called a catchment area. Community mental health centers are in nearly all cases administered by local nonprofit corporations which are responsible for the delivery of services. As noted above, in recent years the Federal Government has placed a heightened priority on centers providing specialized services to meet the needs of the chronic patient population, including the deinstitutionalized. (U.S. General Accounting Office, 1979)

The Developmental Disabilities Act (Public Law 95-103) was created to provide services to persons who are developmentally disabled. Included in this group are mentally retarded, victims of cerebral palsy, epileptic, and physically handicapped clients. The Developmental Disabilities Act authorizes funds to be administered by State governments through State Developmental Disability Councils. These organizations then fund various projects intended to assist the developmentally disabled to live in the community. This funding is usually in the form of a grant to a specific agency. Developmental Disability funds are quite limited and are often used for short-term demonstration or services-coordination purposes, rather than long-term funding.

The Federal Government funds States on a matching basis to provide vocational rehabilitation services to all disabled persons. The rehabilitation program is administered Federally by the Rehabilitation Services Administration (RSA) and at a State level by a rehabilitation agency often called the Division (or Bureau or Office) of Vocational Rehabilitation. In general, the program funds the evaluation of a client's level of vocational potential, and then provides such services as counseling, job placement, job training, vocational training, education, and placement to help assist the client to become competitively employed. State vocational rehabilitation agencies tend to follow their own evaluation procedures and requirements. Although the rehabilitation act and RSA policy requires State vocational rehabilitation agencies to focus their efforts on severely disabled persons, many vocational programs continue to serve clients who have a relatively high potential for employment. As a result, severely disabled deinstitutionalized clients may not receive sustained rehabilitation services from this program. (Berkowitz, et al., 1975)

The Education for all Handicapped Children Act (Public Law 94-142) makes Federal support

available in order to provide education services in programs and facilities that are as "normal" as possible in nature and style. It covers handicapped students up to age twenty-one, guaranteeing a free and appropriate education. In addition, it requires that supportive services (e.g., transportation, corrective appliances) be provided to the children. Federal funds supporting this program are allocated, for the most part, directly to local educational agencies and facilities.

Despite the myriad of Federal funding programs, it is still probably the case that most funding for deinstitutionalization of clients comes from State Government. This includes both Federal programs administered by States, such as medicaid or title XX social services, augmented by a substantial amount of State-generated tax dollars. Each State supports programs to serve specific disability groups (e.g., mental health, mental retardation, etc.). However, since significant differences exist between these programs, they are not detailed here.

Other Funding Sources

Private foundations and donations are often important sources of funds for services to deinstitutionalized disabled clients. Typically, funding from these sources is not on a long-term basis. Foundations tend to fund innovative or demonstration programs and are not customarily interested in underwriting the costs of ongoing operations. However, startup of community residential programs for disabled clients is particularly costly for agencies, and funds from private donations and foundations can often be obtained for expenses such as renovations, equipment, and furnishings. Private foundation fund policies and funding priorities vary significantly. (Smull, 1980)

In recent years there have been some efforts to combine vocational rehabilitation and client business ventures. This type of funding was pioneered by Fairweather in the "Lodge" programs for psychiatric patients. (Horizon House Institute, 1978; Smull, 1980)

This plan is based on an agency's combining a residence with a supervised work setting for clients. The work setting is often a client-operated small business, such as a cleaning or maintenance service. Income from the business accrues to clients and their living or service costs. There are a series of these arrangements in various agencies throughout the country.

An Example of Multisource Funding

The Community Residential Rehabilitation (CRR) program in Pennsylvania is an example of a program to deinstitutionalize disabled psychiatric clients that utilizes multiple sources of funds and permits significant local program flexibility.

Community Residential Rehabilitation services are transitional residential programs in community settings for persons with psychiatric disability. They provide housing, personal assistance, and psychosocial rehabilitation to clients in nonmedical settings. They may offer either of two levels of care, which are distinguished by the level of functioning of the clients served and the intensity of supervision and training provided. In both levels, the provider (i.e., agency) acts as landlord to the client.

Full-care CRR is a program that provides living accommodations with maximum supervision and a full range of personal assistance and psychosocial rehabilitation for persons who display severe community adjustment problems and who require an intensive, structured living situation. A full-care CRR offers an integrated program of personal assistance and rehabilitation to enable clients to gain optimal independence in residential and community functioning. The services are both intensive and extensive; for example, a full-care CRR has

staff on site whenever a client is present in the facility.

Partial-care CRR provides living accommodations with staff at the sites on a regularly scheduled basis. A more limited range of personal assistance and psychosocial services are offered for psychiatrically disabled persons who display less severe community adjustment problems. A partial-care CRR is also intended to aid clients to reach independence in residential and community functioning.

Pennsylvania's CRR program was fashioned to take fullest possible advantage of the various funding sources available to clients. It provides housing and personal maintenance, psychiatric services, psychosocial rehabilitation, and services coordination.

Housing and Personal Maintenance Costs

The provider agency purchases or leases group homes, apartments, or other types of housing. Clients then rent this service from the agency with a portion of their income from SSI, SSDI, or general assistance. Food and other necessities are provided by the agency or the client; the rent is reduced. In at least half of these facilities, client income is supplemental through HUD section 8 housing assistance payments, State supplementation of SSI, mental health agency funds, or other local community mortgage or housing assistance funds. Clients may also benefit from State rent rebate programs for the disabled, food stamps, and energy assistance programs. The agency therefore supports the housing and personal maintenance services through the various programs designed to maximize the client's income level to enable living in the community.

Psychiatric Services

Clients receive the psychiatric services they require from outside agencies funded in most instances by medicare, medicaid, and Federal CMHC funds. Because of their income level and disability, CRR residents are typically eligible for medicaid and attend clinics or psychiatric day treatment programs for up to six hours per day. Although clients themselves do not pay directly for these services, the agencies providing such care are reimbursed by a combination of Federal and State funds.

Service Coordination

Service coordination (case management) refers to a process in which each CRR client receives a functional assessment, a service plan and ongoing service coordination. For the CRR program this is provided by the agency that provides the housing, psychosocial activities, and supervision. It is funded by a combination of State and local funds which are paid to the agency on the basis of the number of clients served.

There are currently 2300 such CRR client spaces and more than 25 provider agencies in 400 sites in Pennsylvania. Although they all follow this general funding model, there are significant individual agency and client variations. The models differ in terms of rehabilitation ideology, level of staffing, and costs of service. Each is designed to meet the needs of the clients, the characteristics of the funding streams, and the community standards of the area in which they are located.

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IV. System Design, Social Change, and Service Linkages

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"Whoever desires constant success
must change his conduct with the times."

N. Machiavelli, 1520

In addition to "System Design, Social Change, and Service Linkages," we could also title this chapter service design, social linkages, and system change, or service change, system linkages, and social design. Each combination has a slightly different twist and yet each accurately reflects the issues and concerns to be considered when planning for community-supported systems for deinstitutionalized persons. However, individually none of these issues is simple. When they are compounded one upon the other they become increasingly complex.

By focusing from the start on the client to whose benefit all these efforts are directed, perhaps we will be able to maintain appropriate priorities throughout the remainder of our discussion. Basically, we are addressing the needs of people who frequently lack a variety of basic living skills, abilities, and attitudes that most of us take for granted. Some have spent an extended period of time living in an environment which fostered—or even insisted upon—dependency. The institutionalization period for others may have been just long enough for them to lose their boarding room or apartment, their job, their insurance coverage, their social contacts and their self-esteem. Dependency upon the community's human services system is thereby created, even with some of the short-term institutional dischargees.

Obviously, the dependency problems created by the institution are exacerbated by the individual's maladjustment problems. These problems may be antisocial behavior, debilitating health condition, mental illness, developmental disability, or any combination of these or other conditions. Although much improvement in functioning can be achieved within an institutional setting, these gains often weaken or dissipate when the client returns to the community. (Diamond, 1979) Therefore, we have a subpopulation of people with maladjustment problems, learned dependent life styles, and all of the basic needs which each of us experience: food, shelter, clothing, money, friends, transportation, medical care, education, recreation, and a sense of worth. (Turner and Tenhoor, 1978; Benjamin and Ben-Dashan, 1979)

It would be helpful here to reconsider the configuration of multiple community-supported services and linkages existing between them for meeting these different needs. The structures of community services and agency systems were originally built largely without the benefit of a master plan. These different services and systems were developed at different times to meet

different needs. As early as 1952, Buell, et al., in their *Community Planning for Human Services*, observed that professionals and agency specializations were posing service-relationship problems only slightly less confusing to professionals than to the citizens of their communities. (Buell, et al., 1952) These same specializations and resulting problems they create are part of today's confusion.

Some examples of existing agency-systems with separate specializations are: Social Security Administration, Department of Housing and Urban Development, Rehabilitation Services Administration, Social Services, Community Corrections, Public Health, Mental Health, and Mental Retardation. Within each of these agency-systems, there are subsystems for providing their specialized services, such as income maintenance, housing, employment and job training, etc. Also, within each of these agency-systems, there are subsystems for attending to the support services necessary for the success of their specialized service. Consequently, each agency-system integrates subsystems to meet all the needs of their clients with fine tuning applied to their area of speciality. Ostensibly, one individual may be concurrently receiving supportive counseling from the local community corrections agency, a vocational rehabilitation program, the welfare office, the local public housing authority, the parole officer, the community mental health center, a priest, and/or the family.

It is certainly a "land of plenty" when we consider the example above. But more is not necessarily better; it does not assure effectiveness and certainly raises concern for efficiency. These specialized services and systems are found at multiple levels of governmental bureaucracies. Since the traditional view of top-down authority and control places the Federal Government at the top, Figure 4.1 reflects tradition. (Our current administration at the Federal level may create some changes in this arrangement.)

Figure 4.1. System Levels

Federal Agencies
(Central and Regional Offices)
Intermediate Bureaucratic Level
(Municipal, County, Regional, State, etc.)
Service Providers
(Private, Public, Institutions, Churches Service Organizations, Self-help, Families, etc.)

Although it is not clearly demonstrated, there are many connections between each level, not just one. Consider the center stalk as a long-distance telephone cable with many different communication wires. Without becoming overly concerned with the diagram, it can be easily seen that an individual citizen can be impacted by many specialized systems from a variety of bureaucratic levels. At different times this can be either positive or negative. The positive

aspects include the opportunity for a multitude of services available to meet the needs of any individual. Among the negative concerns are questions regarding the true accessibility of such a myriad of programs and, of course, the necessary and appropriate linkages of services to meet the needs of any one citizen.

Although it is necessary to note that these various hierarchies and levels of influence exist, we will consider the local community and its service providers. This chapter focuses first on the concept of community and second on systems theory. The components of community are considered, as is the planning required to effect community change. After a general review of systems theory and design, the application of systems theory to the provision of human services is explored.

The Importance of Community

A discussion of 'community' is important here because it is only through the established elements of a community that necessary interpersonal and institutional community supports become accessible and systems become generalized. The reintegration of deinstitutionalized persons back into the community is not accomplished by agencies and followup services alone. Lasting success is achieved when the community accepts these persons as valued members or citizens, even though they may not be fully functioning.

A community can be viewed as an extensive yet sprawling network of subsystems with representation of special interest groups and organizations. The relationships between these subgroups, according to Bates and Bacon (1972) and Bates and Harvey (1975), are of two basic types, exchange and coordinative. Therefore, to understand the community, attention must be paid to the representatives of the various subgroups and to the types of relationships between them. Nix (1977) agrees with Buell, et al. (1952) when he claims that the exchange and/or coordinative forces which underlie community-wide cooperation are not so much common goals as they are interdependencies brought about by the increasing specialization of professionals and agencies. Nix defines community as "a social system whose function is to manage the competition and conflict which arise out of the necessity to exchange limited goods and services which, in turn, arise out of division of labor in society and the scarcity of resources."

In an early view of the community as a social system, Sanders (1958) developed a list of nine major functions of a community: (1) recruitment of new members; (2) communications; (3) differentiation and status allocation; (4) allocation of goods and services; (5) socialization; (6) social control (allocation of power); (7) allocation of prestige; (8) social mobility; and (9) integrating through adjustment (internal accommodation and adjustment to forces outside the system).

Several of these functions are very relevant in providing critical community supports for deinstitutionalized persons, especially the allocation of goods and services, socialization, and integration through adjustment.

Next, it would be helpful to consider some general conditions surrounding how a community typically addresses the needs of its deinstitutionalized population:

- A large number of the reintegration concerns of deinstitutionalized clients are known by religious leaders, family members, private physicians, and counselors, self-help groups, institutions, and others, not only by human service agencies;
- There are a large number of persons with dependency and maladjustment problems who receive no help at all from professional sources;
- The deinstitutionalized persons and their families often experience disorganization so pervasive and chronic that they occupy a greatly disproportionate amount of uncoordinated services from a multiplicity of agencies;

- The process of asking for and receiving help in today's complex society can be both overwhelming and difficult. Although there has been some relaxation of the negative injunctions against becoming dependent, there are also persuasive expectations that the individual seeking help define himself in a dependent role, such as that of patient, welfare recipient, or sinner, which to some extent automatically makes him a stigmatized member of society;
- Interagency linkages and cooperative efforts between the various community groups which either formally, spontaneously or casually provide supportive interventions can strengthen the help offered and the potential for community acceptance.

These five points support the notion that a community-oriented, systems approach could and would be effective. For years, politicians (community leaders who are often the funding decisionmakers) have been asking for the application of a systems approach to a variety of pressing problems. Furthermore, in the late sixties, there was an acceptance that general systems theory was definitely applicable to the human sciences. Buckley (1967) argued that "Modern systems research can provide the basis of a framework more capable of doing justice to the complexities and dynamic properties of the socio-cultural systems." Grinker (1967) extended this view even further: "If there be a third revolution (i.e., after the psychoanalytic and behavioristic), it is in the development of a general (system) theory." The sociocultural system for the reintegration of deinstitutionalized persons into the community must actively recognize and apply the general systems theory within their planning and implementation efforts.

Examples of specific program principles and models are offered in a later chapter. But the development of needed community linkages and networks requires a continuation of the discussions of the late sixties into a description of a community-supported system, its parts, its objectives, and its environment, before specific programs become relevant. In many instances, the establishment of these systems may impose change on currently operating subsystems, programs, and individuals.

To plan for the process of community change for establishing critical program components and their service integration, we benefit from the three basic assumptions presented by Nix (1977): (1) technical change includes social change; (2) a clear description of what is to be changed is essential; and (3) there are differences between the subgroups of communities, as well as between communities as a whole. Clearly, as Etzioni (1972) expresses it, "What is becoming increasingly apparent is that to solve social problems by changing people is more expensive and usually less productive than approaches that accept people as they are and seek to mend not them but the circumstances around them." Therefore, we must give attention to each local community's character, service functions, and subsystems for deinstitutionalized citizens in addition to the direct service activities being offered.

When planning for community change, the following principles should be kept in mind: (1) people will both resist and accept change; (2) when one part of a social system changes, change and adjustment are also required in other parts of the system; (3) there are both negative and positive effects of any change; (4) the members and groups of a system differentially bear the cost of social change; and (5) other problems usually arise with the solution of one. These points are not presented to dissuade consideration of change, but rather to maintain a realistic view during the planning process of the potential tensions and outcomes which may arise and need to be anticipated.

A Systems Approach

For nearly 50 years, "systems" has been a fashionable catchword to identify a variety of problems and their solutions:

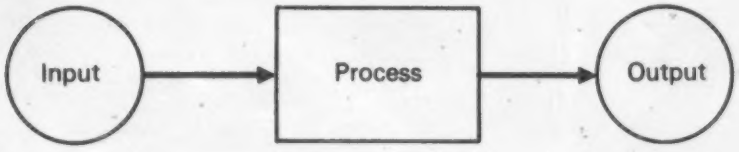
> In the last two decades we have witnessed the emergence of the 'system' as a key concept in scientific research. The tendency to study systems as an entity rather than as a conglomeration of parts is consistent with the tendency in contemporary science no longer to isolate phenomena in narrowly confined contexts, but rather to open interactions for examination and to examine larger and larger slices of nature. (Ackoff, 1959)

Scott (1963) observed that the theory of formal organizations is "framed in philosophy which accepts the premise that the only meaningful way to study organization is to study it as a system .... modern organization theory leads almost inevitably into a discussion of general system theory." In studies of systems it is frequently recognized that the translation of mechanical and formal systems to ones for human services often incurs problems with the "human element." However, even though Boguslaw (1965) considers the "human element" as the most unreliable component of their own created systems, Hall (1962) points out the distinct advantage of creative thought provided by human involvement.

The appropriateness of applying general system theory to human services is further supported by Karl Menninger's (1963) admission that he has based his system of psychiatry on general system theory and organismic biology. Similar references can be found in the literature for corrections programs, for health care programs, and for other human service programs dealing with deinstitutionalized populations.

A paradoxical condition is experienced when there is no clear definition of "system" and we then proceed to use "system" in our discussions. The most elementary form of a system and the most commonly referenced form in human services addresses three basic elements: input, process, and output. Figure 4.2 places these three elements in their most common perspective.

Figure 4.2. Simple System Scheme



We need to move beyond this extremely simplistic view of a system, however, if we are truly committed to a systematic approach for community-based services. Too often, there is a reluctance to take a closer look at the intricacies of the process phase. We are more than willing to study the characteristics of the "input," our clients, and perform extensive needs assessments. We will also evaluate the change in the client, the "output," and the community's acceptance of those people. But often, those in charge of review and evaluation will resist any close attention to their own performance (through the activities of the process phase) as though their professionalism were being threatened. This defensive attitude of some professionals must be challenged. For many, the challenge may prove to be supportive when the results are tallied; for others, there may be good cause for their fears.

Moving beyond the most simplistic scheme for a system, let us first consider a basic definition of a system and its components:

> A system is determined by a given set of objects, properties and their relationships. The system objects are input, process, output, feedback and restriction ... There are three separate sub-processes ... the basic process, feedback and restriction. The basic process transforms input into output. Feedback performs a number of operations: it compares the actual output with an objective (a model output) and identifies the difference; ... and it interacts with the basic process with the aim of achieving the objective using the actual output. The restriction is initiated by the purchaser of the output system.

> Every system consists of subsystems ... The boundary of the system is determined by the separation between the totality of inputs, processes and outputs (required to operate a given system), and the surrounding environment ... A problem situation is characterized by the difference between the necessary (desirable) output and the existing output. (Nikoranov, 1969)

The elements that need to be common to all systems are identifiable entities and identifiable connections. Do our systems for the deinstitutionalized citizens in our communities have both distinct, identifiable entities and clear, identifiable connections? As existing systems are analyzed, problems recognized and solutions recommended, new systems are essentially being designed.

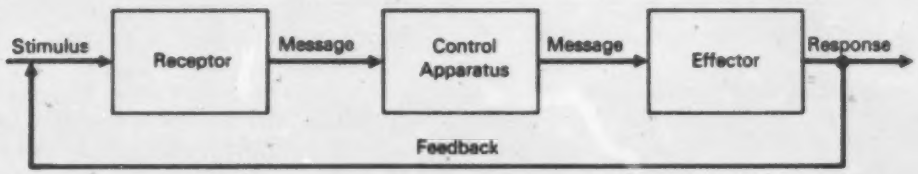
There are characteristics of systems which should be considered when designing one. Jordan (1960) proposes the following classification of three bipoplar dimensions as a possible taxonomy of systems characteristics.

- Structural-Functional (Static-Dynamic): What emerges as a structural figure and what emerges as a functional figure is determined by the time span under attention.
- Purposive-Nonpurposive: Purposive behavior is directed either toward the environment or toward the system itself. Man-contrived systems are production systems and, hence, are purposive.
- Mechanistic-Organismic: It is possible to change or remove elements and/or the connections between them. A system in which the remaining elements, and their connections, undergo no change when this occurs is considered mechanical. Where an effect is felt and a reaction occurs, it is an organismic system which exists.

From these three bipolar dimensions, it is easy to define the human services system as functional, purposive, and organismic. There are other peripheral properties of systems, particularly of organismic systems. However, attention must be focused on the central properties of organismic systems, in that little will be learned from its peripheral aspects.

Another set of dimensions universally accepted is that of open and closed systems. The basis of the open-system model is the dynamic interaction of its components while the ultimate objectives are open to frequent alterations. The basis of a closed system, sometimes referred to as the cybernetic model, is the feedback cycle in which, by way of feedback of information, a desired value is maintained, a target is reached, etc. (von Bertalanffy, 1968) A simple feedback scheme as von Bertalanffy represents it is found in the Figure 4.3.

Figure 4.3. Simple Feedback Scheme



You may recognize a correspondence between this scheme and the process for reintegration of the deinstitutionalized through community-supported systems. Certainly we can agree that the stimulus for our system would be the identification and/or referral of a deinstitutionalized person. The eventual response or output of our system would be the individual's attainment of the highest level of independent functioning of which they are capable, combined with the community's acceptance of them. The components of this scheme correlate quite clearly with the input and output elements of the simple system in Figure 4.3.

There is an expansion of the process component from Figure 4.2 to Figure 4.3. Within the "Simple Feedback Scheme" consider the substitution of "case manager" for the receptor, of a "community human services team" for the control apparatus, and of a "treatment process" for the effector. It is very feasible that messages could flow from the case manager to the community human services team to the treatment process.

The feedback cycle provides a methodology for the maintenance of a desired value. The feedback cycle is, in fact, the basis of a closed, or cybernetic model. Initially, the emotional reaction to a concept which proposes a "closed" system for human services will be that of protest and rebuttal. The hue and cry will be that we must be "open" to the changes within people and to the changes within society. There is no argument with these reactions. The human services system was earlier defined as also being functional, purposive, and organismic. It is the organismic dimension of the system which will allow for, and in fact demand, fluidity within the system so that the nuances of the human element can be taken into account.

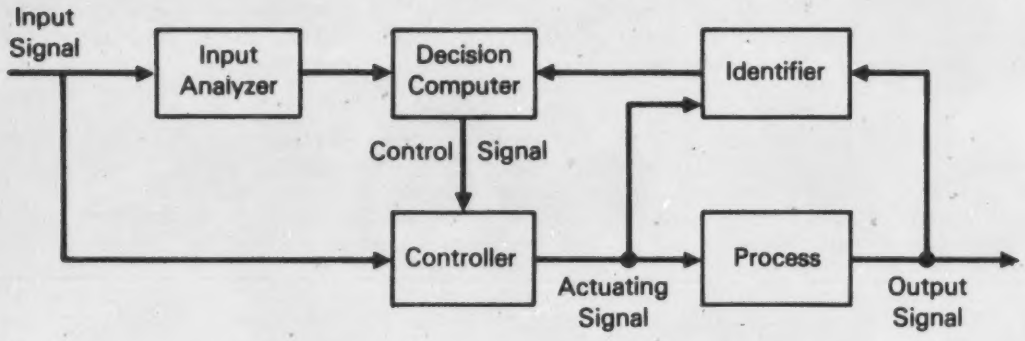
The feedback cycle is critical for quality control. The feedback of information regarding the progress and/or outcome of the "treatment process" must return to the point of origin to determine the system's effectiveness. It is incumbent upon the human services system to explicitly state its desired outcome, to work toward it clearly and distinctly, and then to evaluate the dynamics of its accomplishments in relation to its predetermined target.

An example will clarify this point: If a construction company sold its services with a promise that so many units would be completed within a given period of time and that those units would maintain a predetermined level of quality, that company would perform to meet those conditions or go out of business. Surely they would not be so foolish as to promise more than they were able to produce. Therefore, both the company and the community receiving of their services would have common expectations of the product. It behooves the company periodically to assess its accomplishments to determine whether adjustments are necessary, i.e., extra shifts, higher quality materials, more appropriate labor, different subcontractors, or fewer employees.

A human services system can gain insight from this brief example of a private, for-profit approach to services. For a human services team whose focus is deinstitutionalization, there are obvious expectations of the system's product: reduced institutional episodes, the client's improved community living skills, and the community's acceptance of the client. It is also true for the human services team that it would be foolish to promise more than they are able to produce. Thus, the human services system should engage a feedback loop by which to assess its accomplishments and determine whether adjustments are necessary. This is not meant to imply that assessment is never attempted in the human services, but that it is rarely done within a systematic framework or specifically linked with the "desired value."

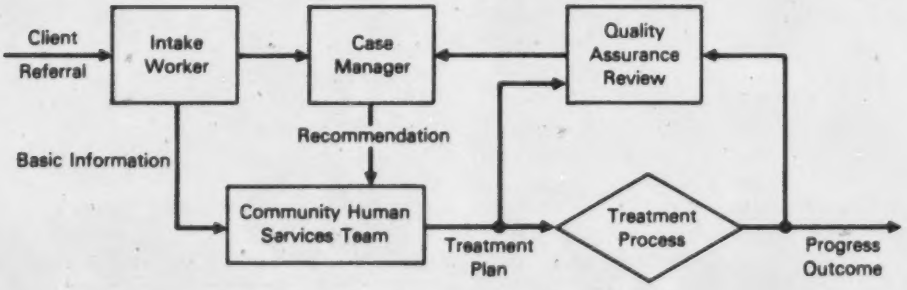
The translation of the Simple Feedback Scheme introduced several new concepts: "case management," "community human services team," "treatment process," and "quality control." These will be discussed in greater detail later. At this point, it is important that there is an understanding and acceptance of the applicability of formal systems' concepts to the planning and implementation processes for community-based human service systems. This simple feedback scheme offers a clean, disentangled view of the system. Becoming a little more sophisticated (or perhaps a little more entangled), let us take a look at the Basic Adaptive System (with feedback) as proposed by Hall (1962):

Figure 4.4. Basic Adaptive Scheme



Hall considers systems of social organization as always involving adaptive behavior. This type of system allows for adjustment as the process characteristics change due to changes in one or more environmental factors (those factors which are outside the system). Clearly, the basic adaptive scheme reflects the process necessary for a basic agency-community support scheme for deinstitutionalized persons. For the operational application of this scheme, consider Figure 4.5:

Figure 4.5. Basic Agency-Community Support Scheme



To understand the elements of the basic agency-community support scheme we must review the definitions of the five process blocks: Intake Worker, Case Manager, Community Human Services Team, Treatment Process, and Quality Assurance Review.

- Intake Worker - the contact person within an agency or organization.
- Case Manager - the person who has the decisionmaking responsibility for assessing the client's strengths and needs and for facilitating the client's access and effective utilization of resources necessary to meet that need. In smaller agencies or organizations the intake worker and the case manager may be one and the same person, although this is not the ideal.
- Community Human Services Team - a group of representatives of relevant human service agencies or organizations. The case manager, providing recommendations for a specific client, automatically becomes a member of the team when that client is discussed. It is also

important that the team members have the authority for actuating resources necessary for an effective treatment process.

There may be different team compositions within the community for different client populations. Some people may be on several teams, but with a different role and level of responsibility. For example, the sheriff may be on a community human service team for ex-offenders returning to the community, as well as on the team for the discharged client from the State home and training center for the mentally retarded, and so on. The mental health counselor, the public health nurse, the local rabbi, and others may find themselves responsible for a variety of community human service teams. But in each instance there is likely to be a variation in each representative's function and level of authority from team to team. Based on the size of the community as well as the size of the agencies or organizations, the representatives may or may not be the same individuals as those on the various community human services teams.

Each community human service team decides which agency or organization is considered relevant. According to Hoag (1956) there are two classic errors regarding relevant alternatives within a system: (1) an unduly restricted range that excludes really interesting alternatives; and (2) an impossibly broad comparison of the total universe of alternatives. These errors can certainly apply to the compositions of these teams. The variety of service providers at the local level, as indicated in Figure 4.1, are broad. There are those in the private sector, those in the public sector, the institutions, the churches, social organizations, family and friends groups, service agencies, self-help alliances, and many others. It may be necessary to have a core group with auxillary members. It is critical that both institution and community-based service providers are represented if continuity of care is to be maintained for the deinstitutionalized clients.

- Treatment Process - a multiplicity of subsystems which are actuated through the treatment plan by the community human services team. Hence, these subsystems will depend upon resources from the various agencies and organizations represented on the team and are not limited to those resources of the intake agency or organization.

To focus the direction of the full set of potential objectives of a treatment process, it is useful to consider the five broad objectives defined by the State of Michigan, Department of Mental Health, 1980. They are applicable to services typically needed by deinstitutionalized clients with maladjustment problems other than mental health. The five categories are: Prevention, Crisis Resolution, Psychosocial Adjustment, Habilitation/Rehabilitation and Maintenance/ Sustenance.

Prevention programs are aimed at reducing the incidence of emotional impairment or developmental disabilities by identifying and impacting on circumstances effecting the individual and environment.

Crisis resolution is to be used in all cases opened in response to acute mental, emotional, or behavioral stress for the purposes of reducing the stress, and ensuring the safety of the client or others. It is also effective for currently open cases in which the client experiences acute enough stress to cause a substantial revision in the ongoing treatment plan.

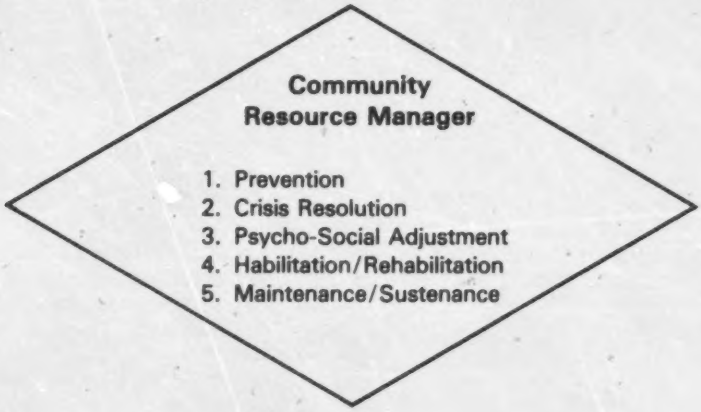
Psychosocial adjustment is to be used in all cases in which the primary reason for intervention is to improve the client's functioning within family, school, or community life when the client is experiencing problems that are not severe enough to be considered a crisis.

Habilitation/rehabilitation is to be used in all cases in which the primary reason for intervention is to increase basic self care, daily living, and work related skills or to provide case management services to facilitate such skill attainment for the purpose of increasing the client's capacity for independent living or maximum functioning. This objective may be used for clients who are living in dependent arrangements, living alone, or those who are living with family or friends and who would require dependent care if the family or friends could no longer provide for the client.

Maintenance/sustenance is to be used for clients who have attained optimal functioning levels through psychosocial adjustment, crisis resolutions, or rehabilitation/habilitation services, and for whom continued services are required to sustain achieved functioning levels. This objective may also be used for clients who have never received other mental health services, but require services to prevent deterioration of existing functioning. The maintenance objective should not be used for clients for whom improved functioning is a treatment goal. The client is almost completely dependent on the system to maintain present functioning level.

The treatment process not only needs to be clearly directed towards an outcome, but also requires a community resource manager. The role of the community resource manager is slightly different from that of case manager even though it may be the same person. It is the responsibility of the community human services team to determine the most appropriate person or organization for followup through the treatment process. It is possible that the case manager, presenting recommendations to the community human services team, may be a public health nurse and the community resource manager may be the sheltered workshop supervisor, the social services case worker, or any other member of the team based on the thrust of the treatment plan and the objective of the treatment process. Figure 4.6 presents an expanded view of this complex element.

Figure 4.6. Treatment Process



Community Resource Management is critical if the client is truly handicapped with dependency and/or maladjustment problems. Barriers to the network of community resources are legion. (Bassuk and Gerson, 1978; Turner and Tenhoor, 1978; Caragonne, 1980) In a recent paper by Waters (1981), an excellent example of the complexities involved is depicted:

> For instance, to get medical care, the (mental health) client may have to see a psychiatrist who will certify mental disability so the client can get Medicaid. Yet, Medicaid in turn is administered (in Colorado) by the Department of Social Services, which will require the prior approval of (and a visit by the client to) the Social Security Administration. Only then is the client ready to approach the medical care establishment, which has its own complex intimidating bureaucracy. Another barrier comes at entry to an agency. Simply completing the usually extensive application procedures, with the demands for pages of paperwork, is usually beyond the tolerance of many clients . . . The client who does not meet the criteria for the particular agency at which he or she has finally arrived, usually after much delay and after overcoming considerable anxiety, is then faced with beginning all over again. This is simply more than many clients can handle.
>
> Agencies also compete for control of the client's life. The Department of Social Services may have assumed legal management responsibility for the client's life through its Adult Protective Services branch. If the client should then commit a series of minor legal offenses, the Department of Community Corrections may assume responsibility through the criminal justice system (deferred prosecution,

probation, etc.) These agencies often give complex, pervasive directives to the client. The same client may also have a treatment plan through a mental health center therapist. The author (Waters) has had experience with some clients who had two or even three "therapy" sessions a week, each from a different agency, each of which had assumed major responsibility for the client.

This testimony is not unusual, particularly for the deinstitutionalized population. Consider the frustrations that a fully functioning individual would experience in these situations if he or she were left alone to resolve all of the barriers that may arise. The deinstitutionalized person can only hope to successfully negotiate this maze with the assistance of a community resource manager, who has developed the skills, knowledge, attitudes, and abilities to move through these subsystems.

- Quality Assurance Review - A review based on the criteria of professionally accepted norms of clinical practice, professional codes of ethics, current research and evaluation findings, and existing state and federal standards, rules and regulations.

This element of the basic agency-community support scheme can also become fairly complex depending upon the agency or organization involved. This subprocess of the system demonstrates to the client and the community that the treatment process has provided optimal care. Quality assurance review "is the responsibility of an agency to demonstrate that ... practices are performed, documented, and evaluated in order to determine the effectiveness of the procedures involved .... In reaction to emerging and continuous requirements for internal reviews ... programs need to integrate their quality assurance efforts into the total administrative activities of the agency. This necessitates active incorporation into the total ongoing management structure of the organization. Without this crucial component, quality assurance is reduced to various disjointed efforts with little or no system-wide impact." (Winfrey and Olson, 1980)

A comprehensive quality assurance review includes program evaluation activities, program quality assurance reviews, client outcome studies, staff skill delineation, clinical staff development, utilization reviews, and quality of treatment reviews. An extensive explanation for each of these can be found elsewhere in the literature. For the purpose of this discussion, program quality assurance reviews must address the appropriateness, effectiveness, and efficiency of the treatment process. The results of the review must be fed back to the case manager for the continuous adjustments required by an adaptive system.

The question we must now address is, How does this theoretical discussion apply to real life? First, the specific terms and functions described in the preceding few pages are not set in concrete or inviolate. In some States and communities, existing systems will employ more or less differing terms and definitions of these functional elements. In the same vein, some of the sequences and interrelationships outlined below may also unfold somewhat differently in different locales. The point, then, is not that the system described (i.e., actors, functions, and relationships) is the only or ideal arrangement for all to emulate, but rather that it is a prototypical system illuminating the essential processes which should be in place. With these caveats in mind, let us perform a quick overview of what this particular scheme is suggesting.

First, a client referral puts the system in motion. An intake worker is charged with three functions: the identification of an appropriate case manager, (i.e., geriatric specialist, alcohol counselor, parole officer, etc.), the completion of release of information forms and the notification of the community human services team. This notification is not a perfunctory exercise. It alerts other human service providers that an individual has entered the system. They may (in fact, often) have had or are having contact with this person and will be better prepared when the team convenes. This dual notification also offers a check and balance to ensure that persons are not lost within the system; but instead that care has begun.

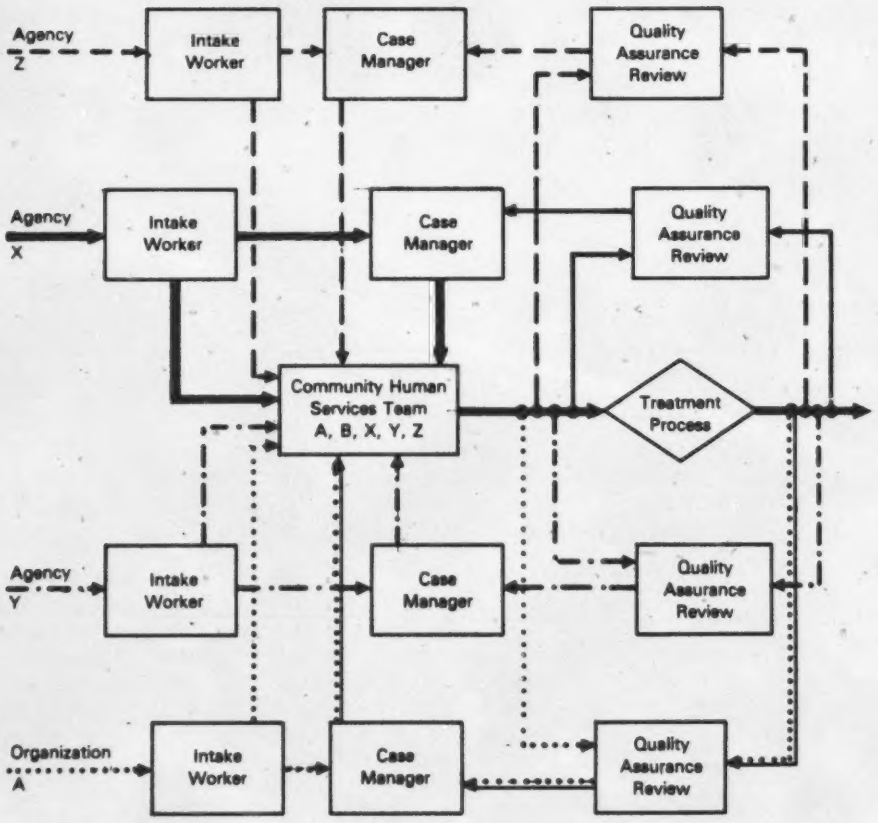
It is the responsibility of the case manager to prepare recommendations for the community human services team to consider in developing a treatment plan. The recommendations are developed with the knowledge of the results of quality assurance reviews performed for

similar client referrals. The case manager presents the recommendations to the team and becomes an active team member in finalizing the treatment plan.

The treatment plan maximizes the coordinated efforts of each of the agencies and organizations represented on the human services team. The plan has two critical elements: an identified community resource manager and a coordinated set of activities directed toward a specific objective. The treatment plan then feeds directly into the treatment process while it also enters into the quality assurance review. These parallel activities once again provide a safety catch within the system's process by which oversights can be caught.

Throughout the treatment process it is the role of the community resource manager to monitor, evaluate, and document the client's progress toward the treatment objective. At least every 6 months, there should be input into some phase of the Quality Assurance Review process—this is the beginning of the feedback loop. When the review process is accomplished, the results are fed back to the case manager who then assimilates the information and carries it back to the community human services team. This full cycle of feedback is important whether change has occurred or not.

Figure 4.7. Community-Based Support System Scheme



Several principles of systems logic derived from attributes of human behavior might be helpful to consider at this point. These principles are adapted from Wright (1960): (1) a system should be arranged in order to provide rewards for appropriate behavior; (2) cues provided by the system should be structured in such a way as to be compatible with existing values, beliefs, and sanctions; (3) systems should enhance learning by providing appropriate warnings and reinforcements and models for imitation; (4) knowledge of results must follow response with minimum delay in time; and (5) this last principle is included specifically for the basic agency community support scheme: the client should be involved with each and every step of the process as much as possible.

As you begin to consider the integration of one basic agency-community support scheme with another, and then another, it is easy to recognize that the common threads for each are participation on the community human services team, development of a treatment plan, and the actualization of the treatment process for a desired outcome. Figure 4.7 illustrates these concepts. The dual lines display how the responsibility of a client may move from the agency of origin to another organization within the total system.

Components of a Community Support System

However a particular locale arranges its services for deinstitutionalized persons, a comprehensive community-support system will need to ensure that the necessary components are provided in order to help these disabled persons help themselves. The following pages present a series of directions, goals, and objectives developed by the Colorado Community Support System (CSS) to guide its activities. Although this system was created to assist one particular deinstitutionalized population—the chronically mentally ill—its perspectives and operations are essentially applicable to all populations of concern.

Measures of outcomes indicating improved functioning are expected within each program component listed below. Some suggested expected outcomes are included at the end of each program component description.

Community Involvement

Concerned community members should be involved in planning community support programs. They may volunteer their services or resources, provide jobs and housing, and become friends with mentally disabled people who are functioning in normal social roles. The community must accept the responsibility for its mentally disabled members and exhibit this responsibility by establishing a formal structure for advising, planning, and monitoring of services. Such a structure would include concerned community members, consumer representatives, and service providers who meet regularly on "community support issues." A plan for public education about the needs of the target population and the services offered by the CSS should be provided. Public education can be offered through participation in the CSS planning process, presentations at community group meetings, use of local media, involvement of community in volunteer programs, etc. The community should serve as an advocate for the insurance of clients' rights and must seek to guarantee accessibility and provision of services for all its disabled members.

Among the examples of expected outcomes from community involvement are increased community awareness of this population's existence and needs through public meetings and public media announcements; increased community ownership of program and resources for clients by an increased number of volunteers for programs specifically for this target population; increased agency participation with other agencies or community groups by two new affiliation agreements.

Vocational Services

Improved employability can be attained by providing vocational evaluation, a variety of prevocational and actual vocational opportunities, transitional employment, job trial, job-seeking training, and assistance in developing work-adjustment skills. Supportive work opportunities of indefinite duration can also be offered, either in specially designed work situations in commerce and industry, in client-operated self-help businesses, or in sheltered employment.

Expected outcomes from vocational services include improved work skills and habits by having six or so clients experience supervised temporary employment placements, increased periods of time/productivity involved in work activities as shown by 20 workshop participants increasing their weekly income by 25 percent.

Residential Alternatives

In order to obtain or provide appropriate living arrangements in an atmosphere which offers incentives and encouragement to assume increasing responsibility and to exercise self-determination, residential alternatives should be offered. These should include a range of alternatives for various levels of required supervision, independence, and treatment intensity, i.e., lockable and open nursing homes, crisis homes, family care homes, group homes, adult foster care facilities, boarding homes, group apartments, independent living with aftercare.

Examples of expected outcomes from residental alternatives include 10 new residential settings established and occupied by 20 people who would be maintained for a 4-6 month length of stay.

Socialization Programs

Socialization programs should be put in place in order to provide social rehabilitation services. These programs should include but not be limited to helping clients evaluate their strengths and weaknesses and participate in setting goals and planning for appropriate services; training clients in community living skills such as medication use, diet, exercise, grooming, shopping, cooking, housekeeping, etc; these should be taught in the natural setting whenever possible; developing social skills, interests, and leisure time activities to provide a sense of participation and personal worth; organizing age appropriate, culturally appropriate daytime and evening activities for persons who may not be capable of employment but who need a place to go and things to do to help them feel worthwhile.

Expected outcomes include clients participating in communication classes; clients learning and using the public transportation to a shopping center once every two weeks or so; and, clients planning, preparing and attending celebrations such as Thanksgiving Day.

Medical and Mental Health Care Services

Adequate medical and mental health care should be provided, including but not limited to diagnostic evaluation; general medical care; physical rehabilitation, where needed; prescription, periodic review, and regulation of psychotropic drugs as appropriate; and, community-based psychiatric, psychological, and/or counseling services.

Examples of expected outcomes from such services would be complete physical examinations for severely disabled adults at the local public health clinic each quarter; progress from daily participation and supervision in programs at the mental health center to 1 day per week for severely disabled clients.

Crisis Intervention

Crisis intervention services provide 24-hour, quick response crisis assistance aimed at improving community ties. Such assistance should be available to the disabled in their homes or on their jobs, when necessary. There must also be adequate provision for sheltered environments to be used when other options are insufficient. Emergency care in psychiatric crisis should also be provided, with face-to-face intervention as needed involving appropriate community agencies and persons significantly associated with the client for his/her "independent" functioning.

Outcomes from crisis intervention would include interventions (within 30 minutes of an emergency phone call) provided at places of employment resulting in only 90 minutes loss of work time; and interventions in family disputes which prevent client eviction from the home into an alternative setting.

Support for Significant Others

Programs should offer backup support, assistance, and consultation to families, friends, landlords, employers, community agencies, and community members who come in contact with mentally disabled persons, to maximize benefits and minimize problems associated with the presence of these persons in the community.

This support should result in weekly classes (day and evening) established for and attended by significant others to improve their understanding of the needs of the severely disabled client. A "buddy" system for mutual support among the significant others of clients should also be established.

Case Management

A case management component facilitates the movement of clients through the system, so that at any given time they may avail themselves of appropriate services. This would include identifying the population-at-risk, whether in hospital or in the community, through outreach programs which assure that clients most in need of help are aware of the services available to them; helping disabled persons apply for income, medical, and other benefits to which they are entitled by reason of citizenship, residence, or other eligibility criteria; providing supportive services of indefinite duration, designed either to sustain functional capacities or to reduce the rate of their decompensation when they are inevitably declining in ability to function; locating or providing supportive living arrangements of indefinite duration, in which clients may remain as long as they need the support; and establishing grievance procedures in compliance with Division of Mental Health's Standard 27 and mechanisms to protect client rights, both in and outside mental health facilities.

Examples of expected outcomes include monthly meetings with a case manager for each severely disabled client. Also, clients will be assisted by their case manager in applying for public assistance during a 6-month period.

Interagency Agreements

As new policies emerge and new relationships are established within these parameters, agencies, organizations, and individuals will be anxious not to risk loss of their power or autonomy. It is, in fact, important for them to retain the necessary decisionmaking powers and resource distribution control within their responsibilities for the overall system. On the other hand, their autonomy often must be moderated. One vehicle for reconciling these seemingly conflicting directions is the interagency agreement.

Interagency agreements create and mediate change. It is desirable to have these agreements at each of the systems levels (Figure 4.1). Some of those agencies/organizations to be considered at the Federal level are: housing, health and welfare, labor, justice, education, and others; at the intermediate bureaucratic level there may be: manpower development, mental *health, mental retardation, public health, social services,* corrections, housing, and others; finally, at the service provider, local level there are numerous interagency agreements possible: hospitals, jails, nursing homes, employment agencies, public housing authorities, churches, service organizations, and others.

An example of an interagency agreement which has passed successfully through the various levels of bureaucracy is that which has been effected between vocational rehabilitation services and mental health programs. In the spring of 1978, the directors of the Rehabilitation Services Agency (RSA) and the National Institute of Mental Health (NIMH) signed a Cooperative Agreement which provided the momentum for similar agreements at other levels. By summer of 1978, the Executive Directors of the Colorado Division of Rehabilitation and the Colorado Division of Mental Health signed a cooperative agreement. Within months, negotiations on local level working agreements were begun.

A copy of such a local level agreement is presented in Appendix A as an example of the types of mutually helpful service linkages and interagency accommodations that can be developed and implemented, between two separate systems.

Appendix A

Local Level Working Agreement
Larimer County Mental Health Center (LCMHC)
and the Division of Rehabilitation.

I. Purpose

This working agreement is entered into between the Larimer County Mental Health Center and the Division of Rehabilitation in order to assist in operationalizing the Agreement for Affiliation entered into on August 22, 1979. This agreement places a Rehabilitation Counselor, who is an employee of the Colorado Division of Rehabilitation, onsite at LCMHC for the purpose of serving psychiatrically disabled clients for whom responsibility is shared by both agencies.

II. Legal Basis

A. The Rehabilitation Act of 1973, as amended (P.L. 93-112).
B. The Health Revenue Act of 1975, as amended (P.L. 94-63).
C. The Public Health Service Act, as amended (P.L. 78-410).
D. Colorado Revised Statutes, 1973, Title 26, Article 8.
E. Colorado Revised Statutes, 1973, Title 27.

III. Role

The role of both mental health services providers and rehabilitation service providers is to enhance the capacity of their clients to achieve higher levels of functioning. Rehabilitation focuses primarily on assisting a client to function more effectively in the area of productivity or work, while mental health agencies focus more on increasing the client's capacity to function more effectively and independently in emotional, social, and recreational areas. The key issue is that all of these areas interweave and overlap.

However, in the case of the LCMHC, certain areas of primary responsibility have been defined to facilitate service to the client. These areas can be classified under three headings: 1) responsibility of the Mental Health Center; 2) responsibility of the DVR counselor; 3) joint responsibilities.

1. Mental Health Center

- Social History
- Case Management
- Occupational Therapy
- Physical Therapy
- Recreational Therapy
- Within the workshop—ongoing therapy, group activities, onsite clinical supervision, schedule meetings
- Psychiatric Examinations
- Short-term therapy
- Long-term therapy
- Hospitalization for psychiatric problems
- Crisis intervention
- 24-hour Emergency services
- Followup care after discharge from a treatment facility
- Residential treatment services
- Medication regulation
- Partial hospitalization services
- Psychological testing
- Medical and drug use history
- Daily living skills training
- Counseling family members and significant others
- Function is consulting resource for DVR counselor

2. Responsibilities of the DVR counselor (either provided directly or purchased)

- Secure work history
- Secure physical examination
- Within the workshop: screening and referral, ongoing monitoring of work progress, arrange transportation
- Job development
- Consulting service to MHC staff
- Provide for physical restoration when appropriate
- Work skills evaluation
- Work adjustment training
- Vocational training and education
- Short-term sheltered employment
- Long-term sheltered training
- Work-site supervision in competitive employment
- Provision of occupational licenses, tools, and/or equipment
- Job-seeking skills
- Job-placement services

- Vocational guidance and counseling
- Followup services after job placement
- Short-term employment

3. Joint Responsibilities

- Provide consultation and advice to workshop personnel
- Maintain confidentiality
- Evaluate client's motivation to change
- Interpersonal skills development
- Communication skills development
- Consultation and education service—both interagency and to the greater community
- Development of client's social skills, interests, and leisure time activities

IV. Continuity of Care

Liaison is maintained by the DVR counselor with (1) each individual therapist who has referred a client and (2) workshop staff. The VR counselor is available to these individuals at all times. Therapists retain the role of case managers, and a client closed by Rehabilitation can continue to receive services through MHC staff.

V. Referral and Followup

Referrals are made by individual therapists and/or the workshop staff. The VR counselor attends initial presentations of all workshop clients and attends all staffings regarding such clients. Other meetings may be arranged as necessary by various parties involved. The VR counselor maintains contact with the therapist and provides medical information and followup medical service as necessary. Because of the fairly small size of the MHC staff, informal meetings are proving satisfactory.

To refer a client to DVR, a therapist fills out the referral form, meets with the DVR counselor, and if it is agreed that the referral is appropriate, the therapist instructs the client to contact the DVR counselor.

It is understood that each agency is legally bound to protect a client's confidentiality.

VI. Joint Staff Education

The VR counselor is included in all Center staff meetings and may attend training sessions. The counselor has visited all of the teams within the MHC to make initial contact, but more detailed information should be provided to help establish the credibility of DVR within the MHC. The VR counselor will continue to visit teams to develop and maintain satisfactory rapport. As needs are identified, LCMHC staff will be notified of relevant training available through DR.

VII. Use of Facilities

The VR counselor is housed in the MHC and has constant access to the sheltered workshop. At present, the sheltered workshop is the only major facility, outside of the MHC itself, which specifically serves the psychiatrically disabled in Larimer County.

There is a need for a residential treatment program beyond the scope of the current halfway house, which would probably be allied with the workshop. There is also a need for a system of

transportation, both within the Ft. Collins area and throughout Larimer County. Currently, there is limited public transportation available within the city (some buses, no taxis), and effectively no public transportation outside the city. The MHC owns a van, but there are no drivers available on a regular basis, and funds for gas are limited.

VIII. Joint Funding

The workshop serving psychiatrically disabled is presently operating under a shared funding agreement. Foothills Gateway Rehabilitation Center, with grant monies from DR, provides equipment, sub-contracts and staff. LCMHC provides a building and the case management component. DR provides a Rehabilitation Counselor.

Several areas of need, specifically a residential component and transportation, have been identified. These will be jointly addressed if resources are available.

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V. Community-Based Services: Characteristics, Principles, and Program Models

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Introduction

The development of community-based programs to serve deinstitutionalized populations did not take place in an orderly or systematic manner. Rather, these programs emerged in response to a variety of social, political, and professional motivations, some primarily humanitarian in nature, others economically inspired, still others brought about by clinical innovation.

This idiosyncratic pattern of development of community-based alternatives characterizes to a considerable degree all of the major human services systems in which deinstitutionalization policies have made their mark, i.e., mental health, mental retardation, aging, juvenile, and adult criminal justice. Thus, Braun et al., in reviewing outcome studies of community-based programs for the mentally ill, state, "there appears to have been little scientifically based information for planning community programs and for identifying types of patients for whom deinstitutionalization would be appropriate ... new (community) programs took place in response to administrative fiat rather than as the result of controlled, carefully performed experimentation." (Braun et al., 1981) Bradley, describing the deinstitutionalization of developmentally disabled persons, points out "attempts to improve services continue to show little evidence of the strategic precision needed to ensure that changes are successfully integrated into a mature, predictable and ongoing system." (Bradley, 1978) And Scull, reporting on the decision to close institutions for juvenile offenders in Massachusetts about a decade ago, observes, "This was a process the final and most important stages of which took place almost overnight. The initial plans were drawn up only 3 to 4 weeks before their implementation and the final decision to go ahead took place only days before (the closure) began ... Only *after* taking this action did the department begin the task of creating community-based alternatives." (Scull, 1977)

Another factor that has contributed to the uneven pattern of services development has been the differing emphasis in program content and priority employed by the respective systems in implementing deinstitutionalization services. Although all systems have in common the basic objective of lessening or eliminating the institutional experience for their clients, the approaches they use to accomplish this tend to vary in form and emphasis. In the instance of mental retardation, for example, the major thrust has been given to developing community-based facilities designed to provide the most normalizing, least stigmatizing environments in

which formerly institutionalized persons can reside, strengthen social relationships, learn the basic skills needed for community functioning and prepare for the pursuit of job or other productive activities. (Willer et al., 1978) The mental health system, while assigning high priority to these same objectives for clients who have been discharged from hospitals, has focused in addition on developing programs designed to create alternatives to hospitalization itself—i.e., to prevent institutionalization—as well as on programs that modify the length and patterns of care offered within the hospital. (Braun et al., 1981)

For juvenile and adult offenders, the major emphasis has been on diversionary programs such as pretrial adjudication, probation, work release, and assignment to civil commitment procedures, in order to enable individuals either to avoid admission into the penal system altogether or to shorten their stay therein. For discharged offenders, the major priority has been on providing residential settings in the community. (Bakal and Polsky, 1979; Hussey and Duffee, 1980) Gerontologists and health planners concerned with community alternatives for the aged have focused their attention on developing noninstitutional housing environments, such as retirement villages and supervised apartments, group and foster homes, in an effort to forestall inappropriate or premature institutionalization. The institution for this group may be a nursing home, a hospital, or a State mental facility. For persons placed in community-based residential settings, service development for the aged population has also stressed case management and outreach and referral systems. (Kostick, 1978; Huttman, 1975; McFarland, 1976; Newman and Sherman, 1979)

Client Characteristics

There are, on the face of it, obvious dissimilarities in the physical, psychological, and experiential makeup of deinstitutionalized client populations served by the systems under discussion. Clearly, a woman of 75, a juvenile delinquent, a moderately retarded adult, and a schizophrenic in remission will exhibit distinctive needs, motivations and behaviors. Yet, despite these differences, it is often found that in many basic respects deinstitutionalized individuals, regardless of the particular nature of their disability, share a pattern of similar social and personal characteristics. These include: heightened dependency, problems with mastering the skills of everyday living, weakened or nonexistent social and family connections, difficulties in achieving satisfactory interpersonal relationships, poor vocational history and work skills, high vulnerability to stress, and low motivation for seeking out and utilizing helping resources in the community.

These characteristics may be associated with or residual to the condition which required the individual's institutionalization in the first place (e.g., retardation or mental disorder); may have arisen as an iatrogenic consequence of the institutional experience; or may result from a combination of both factors. Numerous writers (Goffman, 1961; Gruenberg, 1967; and Rosenhan, 1973, for example) have described syndromes of personality and behavioral change that frequently occur in conjunction with institutional confinement. Among the reactions commonly exhibited are apathy, loss of self-respect, depersonalization and feelings of powerlessness. And, as Brown et al. caution, the problem is further complicated by the fact that many deinstitutionalized persons are inclined, even after discharge, to adopt living styles which continue their accustomed pattern of dependency and constricted social activity (Brown et al. 1966). These are, without question, significant limitations which act, on the one hand, to depress the client's potential for a satisfactory community adjustment and, on the other, to challenge planners and providers of community-based programs to design service interventions which maximize the individual's opportunities to achieve effective reintegration in society.

Before leaving the discussion of client characteristics, a final point should be stressed. Deinstitutionalized clients come in many shapes, sizes, and patterns—and just as many sets of

needs. Some, like elderly State mental hospital expatients who spent 20, 30 or more uninterrupted years of their lives behind institutional walls, return to society with a feeling of having been uprooted from what they have come to regard as their home—the place that housed, fed, and clothed them, looked after them, afforded them whatever social and recreational opportunities they may have enjoyed. Others, like younger psychiatrically disabled persons, have experienced a quite different pattern: periodic short-term institutionalizations, marginal job and social adjustments; but, at the same time, show a much greater familiarity and identification with living in society. The aged, retarded, and offender populations exhibit comparable variations in their institutional histories, physical impairments, and social and psychological functioning.

It would be of inestimable help if the numbers, proportionate rates, geographic distributions and clinical/social attributes of these groups were charted and available to program planners. These data would provide great assistance in designing, siting, and operating effective community-based services. But, as has been discussed in earlier chapters of this monograph, such information neither exists nor has ever been systematically collected. Thus, planners must rely on needs assessment techniques (as described in Chapter Two) to arrive at the most reliable estimates of the magnitude, service requirements, and characteristics of the groups awaiting care.

Community-Based Psychosocial Service

Since the late 1960's there has been a growing tendency to apply the term psychosocial services to the array of community-based programs that have been developed to serve deinstitutionalized clients. These services have several interrelated objectives; as described by Stein and Test (1978), they are: (1) to assure that clients are helped to secure the material resources such as shelter, food, clothing, medical care, and recreation necessary to support adequately their lives in the community; (2) to assist clients to learn and use the coping skills needed to meet the demands of community life; (3) to motivate clients to persevere and remain involved with life in society; (4) to aid the client to become free of pathologically dependent relationships and to encourage their growth toward greater autonomy; and (5) to foster, and help clients utilize, a supportive system which assertively assists clients to accomplish the above four objectives. To this list might be added these additional objectives: provide information and support to families, neighbors, and other concerned community members; advocate for and safeguard clients' personal dignity, rights to confidentiality, and civil rights and liberties; and help reduce stigma and negative community reactions toward deinstitutionalized clients (Bachrach, 1976; Turner and TenHoor, 1978).

As the deinstitutionalization movement has expanded, so has the range of services that are considered to fall under the psychosocial rubric. Among the programs most frequently identified are: supervised and semi-supervised residential settings; social skills development; recreational and leisure-time activities; job training, work habituation, placement and followup; crisis intervention and crisis stabilization; education; family counseling and support; and case management. In addition, medication review, personal counseling and day care activities are also sometimes categorized as psychosocial programs.

Psychosocial Principles

Before reviewing some principles of psychosocial programs, let us place these programs in context, relative to the broad spectrum of health and social services. Deinstitutionalized clients, as noted above, often require many types of treatment and support services. Sometimes these are provided concurrently, sometimes sequentially. Such services may be offered by hospitals, health clinics, mental health and retardation centers, outpatient clinics, social agencies and/or psychosocial facilities. Although psychosocial services are generally re-

garded as being uniquely responsive to meeting the needs of deinstitutionalized clients, they should not be viewed as the only programs that can effectively serve such persons or as being in a competitive relationship with more traditional treatment methods. In fact, they are often of greatest help when used in collaboration with other treatment techniques such as medication, psychotherapy, counseling, or casework.

With the above in mind, let us turn to the principles which underlie psychosocial programs. They can perhaps best be delineated through comparison with more traditional treatment methods such as might be provided at a mental health center, clinic, or social agency. Presented below are discussions of eight dimensions along which the two types of approaches tend to differ, recognizing again that each approach has a helpful role to play for most clients at one or another stage of their postinstitutional adjustment.

- Normalized setting. Psychosocial programs are usually provided in settings that are more normalized and less clinical in flavor and style than traditional treatment services. Not infrequently they are housed in churches, Y's, family-sized residences, store fronts, etc. Some of them, of course, are located in their own buildings, but in most such instances care has been given to creating a homelike and informal atmosphere. Missing are such institutional trappings as hard-benched waiting rooms, nurses' stations, and uniformed staff. Instead, the feeling conveyed is that of a club house or private dwelling.
- Emphasis on experiential learning. Psychosocial programs are designed to effect change through experiential learning. A variety of activities and opportunities for social interaction are usually provided and, even more, tailored to meet the unique needs of the individual. Clients may spend as many as 25 to 30 hours each week in the program participating in activities; relating to peers, volunteers, and staff; performing tasks and household chores, etc. Social and behavioral norms are in large part maintained by the group, within established guidelines or limits. In some psychosocial programs, clients select classes or activities in a manner not unlike registration at a school or college. The emphasis throughout is on active participation, on testing out relationships, and on improving skills and confidence through involvement with and reinforcement from others. Traditional approaches, on the other hand, tend to rely on verbal interactions between client and professional as the primary helping mechanism, with such sessions usually taking place 1 or 2 hours a week at the most.
- "Here and now" orientation. Psychosocial services address the client's current needs and directions. They stress events occurring in the present and deal with them so that the experiences gained can be helpful to the client in the future. Unlike many traditional treatment methods, they place relatively little emphasis on prior relationships or earlier setbacks experienced by the client; neither are they inclined to dwell on retrospective analyses of the significance of such prior experiences in predicting future potential for adjustment. The approach is very much one of conveying to the client an attitude that says, in effect, "We don't care that much about all the bad things that happened to you in the past. You're here now and we're here now—and the only important thing is what happens from this point forward."
- Emphasis on strengths. Many traditional health and social services are oriented to diagnosing and treating an underlying pathological condition or impairment that besets the individual. The psychosocial approach, on the other hand, attaches less importance to the notion of pathology and rather focuses on the client's existing strengths and capabilities. Diagnosis and cure, in this view, are less relevant than formulations such as "reducing inappropriate behaviors" and "improving personal competencies." To this end, psychosocial programs utilize techniques such as function assessment scales, goal planning agreements, and performance contracts. These are entered into mutually by client and staff and highlight current strengths while identifying areas in which further improvement is needed.
- High expectancy climate. Psychosocial programs tend to be characterized by a quality of high but realistic expectations reflected throughout the facility's activities and client-staff interactions. This helps transmit and reinforce several important messages to the client:

that his or her motivation to improve needed skills and capabilities is valued; that staff is eager and able to assist in this process; and that the goal of increased independence is shared, valued, and reachable. While traditional treatment approaches may also make use of positive expectations, they tend to do so less actively or consistently and are usually inclined to adopt a neutral or noncommital stance regarding the future outlook for the client.

- Nondoctrinaire approach. Both the philosophical leanings and programs of psychosocial facilities typically are broadbased and eclectic. They incorporate into their programs elements drawn from many helping approaches, such as learning theory, client-centered counseling, behavior modification and cognitive therapy. This readiness to "mix and match" practically diverse theoretical components has the effect of increasing the flexibility and spontaneity of the service provided; the deliberate rationale seems to be, "if this procedure doesn't seem to be working, let's modify it, add a different piece, or try something altogether new until we arrive at a method that does work." Traditional treatment approaches, in contrast, tend to adhere more closely to a preferred therapeutic technique or school of thought. While they too, of course, may introduce changes and modifications in their work with clients, it is often the case that these practitioners are most comfortable relying on the methods they were trained in and that have served them well in the past. This presents little problem when good results are being achieved. However, if progress with a client slows down—or never really begins—responsibility for the low level of accomplishment is more likely to be attributed to the client (e.g., poor motivation, not being responsive, resistance) than to the method being used.
- Practical egalitarian focus. Many traditional treatment approaches are structured such that the practitioner is ascribed superior knowledge and understanding concerning both the problem being discussed and the steps that should be followed to solve it. The helping person thus tends to assume the role of authority figure and provider, and the client the more passive role of recipient of care. Moreover, much of the interactive process often centers on intrapsychic mechanisms (e.g., analyzing feelings, gaining insights) which may or may not have ready transferability to events and situations occurring outside the therapeutic office. Psychosocial programs tend to differ in both respects. First, relationships between client and staff members are usually more balanced and egalitarian. The worker does not presume to have all the answers and encourages interactions with the client that are based on active give-and-take and on mutual suggestions of approaches to solving problems. Hierarchical distances are reduced and everyone relates on a first-name basis. Second, the focus of most activities is placed on the practical concerns of everyday living, i.e., on living arrangements, job finding, social relationships, and integration into society.
- Innovative staffing patterns. Psychosocial programs usually select and utilize staff more flexibly than do traditional services. This is reflected in several ways: hierarchies based in professional discipline and degree are discouraged; functional role specializations (e.g., social workers counseling with families, psychologists administering batteries of diagnostic tests) are seldom practiced; innovative approaches to selecting and using staff, including paraprofessionals, ex-clients and persons trained in fields other than the established health and human services, are commonplace. Most psychosocial programs favor a "generalist" approach regarding staff roles in which workers perform functions more or less interchangeably. Further, they are likely to attach greater importance to the quality of a staff worker's relationship and communication with a client than to the worker's formal credentials. Traditional treatment approaches are more frequently found to maintain staff authority hierarchies, to utilize specialist rather than generalist role functions, and to select personnel from established disciplines who possess appropriate academic credentials.

Program Types and Models

On the following pages, the characteristics and service components of three basic types of community-based psychosocial programs are reviewed. Since appropriate housing is such a critical need for deinstitutionalized persons, a major emphasis is given to this topic. However, the two other important areas of rehabilitative and supportive services that must be planned and provided are also discussed. As noted earlier, the first of these consists of programs offering skills development in socialization, recreation, and similar community-readaptation functions. The second category is geared to helping clients acquire vocational motivations and competencies which will allow them to reenter the work world.

Residential Services

Many formerly institutionalized individuals cannot or should not return to their families. Others have no family to which to return. Still others require various types and levels of supervised residential services to help maintain and improve their functioning. For all such individuals, programs need to be established which are sensitive to their needs and are geared to the achievement of an optimal level of independence.

Although the emphasis of this chapter is on community-based programs, it again should be noted that the problems affecting deinstitutionalized clients are complex and often the consequence of the type of care received within the institution. Since institutional confinement creates norms and behaviors that reinforce dependency, these behaviors are frequently at odds with those needed to survive successfully in the community. Thus, innovative rehabilitation programs within the institution, including special preparation-for-discharge residential settings, may also be considered as part of an overall strategy. Many models for such programs have been developed, including "quarterway" houses, "outward bound" transition units, etc. Designed to create a continuum of related transitional facilities, they have achieved but limited success in preparing clients for community living. (Test and Stein, 1978)

More pertinent, however, are the residential programs serving clients directly in the community, either upon discharge from the institution, or as an alternative to serve a variety of client groups, including those who have had long-term stays, short-term stays, or no institutional experience at all. Usually, they are operated to serve one disability group exclusively, but may combine disability groups, or even include individuals who have no disability.

Numerous writers have commented on the functions served by community-based residential programs. Thus, Sharp (1964) has suggested that such programs help provide clients with places in which to prove themselves socially effective while protecting them from the stresses of too rapid integration into the community. Barton (1962) points out the importance of such programs when clients' family environments are not supportive and their anxieties about remaining in the community can be lessened by living with a similar group of persons. Rothwell and Doniger (1963) highlight the absence of medically oriented supervision, the small and homelike atmosphere, and the anonymity afforded the individual.

The term, "Community-Based Residential Program" (or the more common term, "Halfway House") does not convey a clear-cut meaning. Residential treatment programs and halfway houses differ widely and there is, as yet, no agreed-upon set of definitions which neatly categorizes these facilities. Intake criteria, length of stay, treatment goals, target population served, services offered, quantity and quality of staff, location costs, and other factors tend to be so diverse that a unified classification system becomes difficult to agree upon. One reason for this is that programs have been developed to meet varying needs of their target populations and communities. Another is that such programs tend to reflect the conditions, constraints, and philosophies of their founding bodies and locales. For example, the goal of a residential program working with alcoholics would stress that its residents remain sober. A program for

paroled offenders would emphasize clients' disavowal of further criminal activities. A residence for the mentally ill and/or mentally retarded would focus on teaching behaviors that increase self-esteem and competencies necessary for everyday life.

Modalities

The following types of programs are generally included within the continuum of residential care facilities:

- Foster Homes—family settings in which relatively small numbers (typically, 1-6) of individuals, adolescent or adult, live in a private home with a sponsoring family in a setting characterized by a familial environment.
- Boarding Homes (also board and care facilities)—residential facilities providing room and board to groups of from 3 to 4 to as high as 35 to 40 individuals. Typically boarding homes are operated by untrained proprietors, and offer few services other than provision of room, board, and minimal supervision.
- Halfway houses—community-based residential settings providing transitional living experiences to groups of 6 to 18 clients, with the average number about 12. Predominantly nonprofit, they offer a variety of personal adjustment, counseling, and socialization experiences in addition to room and board. Many halfway houses are free-standing organizations; some however, are affiliated with other organizations such as rehabilitation centers, hospitals, community mental health centers, etc. Most, although not all, are established as transitional residences and operate under time limits which range from 6 to 12 months.
- Apartment Programs (also sheltered apartments, cooperative apartments)—units normally accommodate 2 to 4 persons in apartment settings. They are usually designed for individuals capable of higher levels of independent functioning so that live-in staff are not required. Often affiliated with a parent corporation such as a rehabilitation center, community mental health center, hospital, church organization, etc., they may be developed in clusters or as individual units within apartment buildings. Either the agency or the clients may sign and be responsible for the leasing arrangements.
- Specialized Transitional Facilities (quarter-way houses, three-quarter-way houses—residential facilities designed to provide a transitional experience between an institution and another protected environment, or between another protected environment (i.e., halfway house) and the community. Quarter-way houses tend to be located in or near the grounds of the institution; three-quarter-way houses are usually located in regular neighborhood locales.
- Long-Term Care Facility (also long-term community home, personal care home)—community-based housing for individuals who require long-term or permanently supervised living situations and who may need minimal nursing-type care. Such individuals are usually physically mobile, able to accomplish some of their self-care needs with some supervision, but otherwise tend to lack the resources to cope with the problems of daily living and will seldom be able to live independently in the community.
- Lodges—a specialized residential-vocational model utilized primarily for the mentally disabled in which formerly hospitalized patients are helped to secure, furnish, and operate a communal residence with little or no staff involvement. In addition, lodges typically establish small semi-skilled business ventures to enable the lodge members to become employed and self-sufficient. Lodge-type programs exist in some 20 States throughout the nation. (Fairweather, 1980)
- Domiciliary Care Programs—programs authorized as part of the Supplemental Security Income (SSI) legislation were intended to facilitate residential care for disabled and aged individuals. Special supplementary funding incentives are designed to facilitate the creation of domiciliary care settings which, in general form are similar to boarding home programs as described above. SSI guidelines, however, require additional case management, monitoring, and training procedures to assure the provision of adequate domiciliary

care services, as well as some minimal personal supervisory care by the domiciliary care proprietor.

Given this array of community residential alternatives, it may be helpful to organize them according to certain key variables. Although several typological schema are possible, we shall limit ourselves to the following two, the first based on size of facility, the second on functional level of client. It will be noted that in both tables some overlap exists between categories.

SIZE OF FACILITY

1-4 Persons	5-8 Persons	9-20 Persons	20 or more Persons
Foster home Sheltered apartment Special transitional quarter-way and three-quarter-way house	Group foster home Boarding home	Halfway house Boarding home Long-term Care Facility Lodge	Long-term Care Facility Boarding home

FUNCTIONAL LEVEL

Lowest Functional Level; Needs Regular Supervision	Limited Independent Functioning; Needs On-going Supervision	Partial Independent Functioning; Needs Moderate to Little Supervision	Nearly Independent Functioning; Needs Minimal Supervision
Long-term Care Facility Boarding Home	Quarter-way house Individual and group foster homes Boarding home Domiciliary care Lodge	Halfway house Three-quarter-way house Individual and group foster homes Lodge	Three-quarter-way house Supervised apartment program Cooperative apartment program

Costs of Housing Alternatives

As might be expected, cost factors in this field vary widely, and are somewhat difficult to ascertain. Several variables tend to correlate with costs: the auspice of the residential program; whether it is nonprofit or profit-making; the extent to which additional services (i.e., counseling, recreation, vocational preparation, followup, etc.) are provided; the size and qualifications of the staff; and the condition and location of the physical plant and furnishings.

It is impossible to discuss all of these factors in detail. However, some general trends regarding costs may be briefly noted. First, it is almost axiomatic that the more extensive the total program offering is, the more expensive the residential costs will be; therefore, facilities which provide counseling, resocialization, medical followup, vocational training and the like, as part of the total program, will show higher operating costs. Next, there is a tendency for free-standing facilities to be less costly than those associated or affiliated with parent organizations. This may be the result of duplication of certain administrative overhead and/or personnel costs.

These relationships, as well as the findings presented below, were confirmed in a national study of determinants of costs of residential facilities serving the mentally ill, the mentally ill aged, and substance abusers conducted by Horizon House Institute in 1978 (Piasecki, Pittinger, and Rutman, 1978). The study's results showed:

- Costs for residential services are highly related to the level of services provided inhouse and to the disability group served; in 1976, average per-diem costs for 61 halfway houses surveyed were $19 per client, for 19 apartment programs about $3.25 per client, and for boarding homes about $6 per client.
- These differences in costs are largely attributable to: (1) the provision (or absence) of inhouse rehabilitative services; and (2) the number and type of staff employed by the program.
- Services to mentally disturbed juveniles are typically more costly, averaging in 1976 a per diem cost of about $27.75 per client.
- Startup costs are substantial, often equaling the annual costs of operating the facility. Halfway house startup costs may be 5 to 10 times more per client bed than apartment programs.
- Facilities operated under government auspices were found to have somewhat higher costs than proprietary and nonprofit facilities.
- The rate of inflation for residential services has matched or exceeded the general inflation rate.
- It is uncommon for a single facility to serve more than one disability group or to mix juveniles with adult clients.
- Size, in terms of number of clients, was not found to be a major determinant of costs.

Program Model

Over the past 25 years, a quite extensive body of experience and literature has been accumulated regarding many types of residential programs. The following descriptions and references should offer a helpful overview of the most frequently encountered styles of residential care for the respective disability groups.

Mentally Ill

In many respects, residential programs for psychiatrically disabled clients have been the most diverse, the most carefully assessed, and the most emulated by other systems serving deinstitutionalized clients. Probably the most familiar models are halfway houses and group homes, which have been on the scene since the 1930's, although their growth was quite slow until the 1960's. These programs are defined by the National Institute of Mental Health as "residential facilities in operation seven days a week, with round-the-clock supervision (or a staff member living in) and providing room, board and assistance with the activities of daily living." (Cannon, 1973) Although wide variations exist regarding the quality of inhouse programming, the degree of client involvement in the operation of the facility and the range of activities offered, this is a serviceable definition not only for such facilities serving the mentally ill but also for similar programs serving all the disability groups under consideration.

Until recently, the great majority of halfway house residents—an estimated 80 to 90 percent—had been previously institutionalized, and most entered the facility directly from a hospital. During the past decade, however, there has been a growing tendency for group homes to be used as alternatives to the institution—a tendency that is also found among the other systems providing deinstitutionalization services.

Although the actual number of psychiatric halfway houses in the United States has not been accurately determined (a problem that plagues all types of residential programs serving all

disabled populations), it is estimated that they currently number 500 to 600. (Discussions of the philosophies, methods, and characteristics of several versions of this type of modality are presented by Glasscote et al., 1971; Rausch and Rausch, 1968; Rog and Rausch, 1975; Dincin, 1975; Lynch et al., 1975; Budson, 1978; Mosher and Menn, 1978; and the Florida Department of Health and Rehabilitation Services, not dated.)

Apartment programs are used extensively in providing housing to this group. They vary in a number of dimensions such as degree of supervision, staffing pattern, funding, and leasing arrangements, etc., and may be sponsored by psychosocial agencies, community mental health centers, hospitals, or various community and civic groups. Their popularity has increased significantly in recent years, partly because they are the most normalizing style of supervised housing, partly because they require less staff coverage, and partly because they can be developed more quickly, less expensively, and with less likelihood of community opposition than group homes. Reviews of principles and methods of a variety of apartment programs have been prepared by Goldmeier et al. (1977); Chien and Cole (1973); Riehman and O'Brien (1973); Kresky et al. (1976); and Goldmeier (1975).

The type of community housing program that by far serves the largest number of deinstitutionalized psychiatric clients is the boarding home (also referred to as board and care home). These can be nonprofit or for-profit in auspice (almost always they are the latter) and range in size from a home serving 2 or 3 clients to a facility caring for over 100 persons. In recent years, boarding homes have come under the scrutiny of governmental agencies as well as the public news media because of substandard conditions, exploitative practices, and fire and safety violations that were known to exist in some of these settings. As a result, many States and local communities have mounted a series of new legislative, programmatic, and regulatory initiatives to correct these problems. These initiatives often include developing and enforcing upgraded licensing standards that cover physical and, increasingly, programmatic requirements of such facilities.

Boarding home programs have been criticized strongly by professionals on several counts. As Carling states:

> Some critics charge that it is virtually impossible to maintain an independence-fostering environment in this type of setting. Others indicate overwhelming difficulties in controlling and monitoring such facilities to assure a quality environment ... (T)hey are basically custodial, and ... (just) as the custodial function of large state hospitals was enormously over-utilized so too has this been the case with board and care homes. (Carling 1978)

In response to these concerns, States and local agencies are increasingly sponsoring training programs for boarding home proprietors. These address a range of issues designed to bring about improved client services as well as closer integration with professional facilities and staff members. Such training curricula may include topics such as the nature of mental disorder, mediations, techniques for crisis intervention and dealing with behavioral problems, health and nutrition, and fiscal/administrative management. Discussions about the role and services of boarding homes can be found in Lamb (1979); Lamb and Goertzel (1971); and Segal and Aviram (1978); reviews of training programs for boarding home proprietors in Egan (1978), and Pitman (1974).

Foster care placement for the mentally disabled has received less public and professional attention than have the types of housing discussed above. This form of residential care is unevenly distributed throughout the nation; a few States, notably Michigan, have developed extensive and carefully monitored foster care systems, but most States have not assigned it a high priority. Foster care involves the placement of the deinstitutionalized client into a family home in which one or more members are paid a fee to provide care to the individual. When only one or a small number of clients is placed in a family unit, there usually develops a closer relationship with the caretaker than takes place in a halfway house or apartment program. But as the number placed increases, foster care placement begins to resemble group home or boarding home care. (Carpenter, 1978) For a discussion of the Michigan approach, see Clark

(1978); for reviews of additional innovative foster family care approaches, see Chouinard (1975); and Polak (1978).

Mental Retardation

A great many of the values, principles, and methods noted above for the psychiatrically disabled hold true with respect to the retarded. Strongly influenced by Wolfensberger's (1972) concepts of normalization in designing systems of care for this group, professional and advocacy organizations have advanced steadily and decisively over the past 2 decades on behalf of community-based program development. Numerous States—notably Nebraska, Connecticut, Pennsylvania, New York, California, and Virginia—have fashioned networks of residential programs serving the retarded. Group homes (i.e., halfway houses, community living arrangements, community living systems), apartment programs, and foster care arrangements have been established quite widely, albeit on a somewhat smaller scale than those for the psychiatrically disabled.

Philosophically, programs which return the retarded individual to a family setting tend to be viewed as most desirable for this population. Placement with the client's own family is, of course, the most advantageous alternative. But when this is not feasible, for whatever reasons, the next favored choice is foster care, followed by group home or apartment living. In a few States (California and New York among them) foster care placement is the type of residential care most frequently utilized for this group, but nationally, less than 20 percent of all community placements are to family care. Evaluative studies of this modality show that reinstitutionalization rates are quite high among clients placed with families, ranging from about 30 to 50 percent. (Willer et al., 1978) Halfway houses and group homes, on the other hand, report significantly more favorable readmission rates for their residents. According to studies also cited by Willer, readmission to institution for clients placed in group home programs stands at about 7 to 11 percent, a rate that is even slightly better than that of clients who are discharged to live with their own families.

In keeping with its preference for providing family care for clients, the mental retardation system has innovated the development of a number of family support services designed to assist families in maintaining clients at home. These include: respite care, the provision of temporary residential care for the client whose family is under stress or who needs to get away; homemaker services, in which homemakers or aides are provided to help with the care of the client or with household duties; transportation services, which are offered to families to transport family members or the client to day programs or work-activity centers; and family education at training programs to help parents and other family members deal with the adjustment problems of the developmentally disabled client.

Descriptions of major types and models of residential programs for the retarded are offered by O'Connor (1976); Bergman (1975); Bradley (1978); Paul et al. (1977); Cherrington and Dybwod (1974); Wyngaarden et al. (1976); Bjaanes and Butler (1974); Arnold and Goodman (1966); and Horejsi (1975).

Juvenile and Adult Offenders

As noted earlier, the corrections systems rely on a variety of diversionary programs as their principal deinstitutionalization strategies, one of which consists of group homes, halfway houses, and other residential programs. It would be inaccurate to suggest, however, that these programs lend themselves to an orderly system of definition, classification, and description. Just the opposite is the case; in deinstitutionalization, a field generally characterized by imprecise planning and coordination, by professional disagreements and tugs-of-war, and by damaging community opposition, the correctional field is particularly hard hit. There are many types of diversionary programs including residential alternatives, but their directions seem more or less unclear to the various groups in the system directly involved— planners, staff, and sometimes clients themselves.

As with the other systems, residential services for offenders were largely conceptualized in the 1950's, tested via innovative pilot programs and demonstrations in the late 1950's and early 1960's, and have since experienced gradual but steady growth. Two basic target populations are served—adult offenders and juvenile offenders—and the types of programs for both vary widely. It is difficult to ascertain the number of residential alternatives that currently exist for these populations, but there are probably no less than 300, an estimate that would increase significantly if community-based programs for alcohol and drug abusers (who are frequently categorized within correctional systems and statistics) were included in the total. Auspices vary widely and include Federal and State government correctional authorities, private non-profit social agencies, church and community organizations, county governments, and entrepreneurial operators.

With respect primarily to adult offenders, James (1973) identifies four types of group residential settings that are utilized at different stages of the correctional continuum: probation hostels, which are "alternative means of housing those who, because of unsatisfactory domestic conditions would otherwise have been deemed unsuitable for probation and so committed to a penal institution"; prerelease hostels (also referred to as prerelease guidance centers) designed for persons still in custody and which may be located in a special wing or building on the prison grounds, or in the community; halfway houses specifically developed for inmates who must have both a job and a place to live as a condition for parole; and halfway houses for inmates who remain in prison until the completion of their sentence and who, James suggests, may be the most in need of a supportive transitional residential program.

Spurred by the urgent quest for practical and humane solutions to the enormous problems associated with incarcerating youthful offenders, community-based alternative programs for juveniles have been designed and implemented in numerous locales since the late 1950's. Here again, it is difficult to characterize these programs in a few summary sentences, since their diversity of philosophy, auspice, style, and program emphasis is so considerable. Considerable too, is the continuing debate among authorities regarding the effectiveness, in costs and outcomes, of the programs that have been implemented (see, for example, Cohen, 1979; Bullington et al., 1978; Lerman, 1975; and Scull, 1973).

Critiques regarding the utilization of community programs—as they have been administered in the correctional field—question whether alternative settings actually reduce recidivism, provide more humanitarian treatment, cost less than traditional incarceration methods, or are in fact less coercive than traditional methods. (Cohen, 1979) Nonetheless, most observers support the need for and the objectives of community-based residential settings and the promise they offer, if not necessarily their accomplishments to date. This viewpoint is reflected by Hussey and Smith (1980) who list the "core characteristics" that many, but not all community programs display: a greater degree of interaction with the community; relative smallness; frequent separation of living and punishment situations; greater specialization of program; greater continuity between various program phases; and attention of staff to improving relations with the community.

Three approaches to the decarceration of juveniles through community-based alternatives are noteworthy because they are among the most carefully studied programs and because they have stimulated the development of similar programs in other locales. These are, first the Community Treatment Project developed by the California Youth Authority. This program transferred to community settings youths who otherwise would have been incarcerated in State institutions. Some youths were placed in these settings in lieu of confinement, others after confinement. All received parole supervision. A review of this project and its results is presented by Warren (1967). Second, Highfields was established in New Jersey as a residential alternative for delinquents who would otherwise have been sent to traditional training schools. Highfields featured the use of guided group interaction, a confrontation styled form of group therapy and also the notion of shared group responsibility of individuals' behaviors. As with the California Project above, evaluations of the program were mixed, but fairly

positive. A discussion of the Highfields experiment is found in McCorkle et al. (1957). The third approach follows from Massachusetts, closing of the its correctional institutions and sending juveniles into alternative residential care in the community. In this instance some clients were discharged into these settings, and others placed there directly on probation. The program also innovated the use of advocacy services and trained volunteers who offered support and supervision several hours a week. Reviews of the Massachusetts experiment are found in Bakal (1974), Holden (1976), and Behn (1976).

Among those who have written descriptions of halfway houses for adult offenders are James (1975); Rachin (1975); Kerby (1975); Durham (1974); Seiter et al. (1977); Perlstein and Phelps (1975); and Nice (1964). In the area of community alternative services for juvenile offenders, additional reviews of principles and methods of such programs have been published by Alper (1974); Emprey and Erickson (1972); Handler (1975); Kingsley et al. (1975); Miller (1977); Paul et al. (1977); Sargent (1973); and the United States Congress (1973).

Aged

Note: I wish to gratefully acknowledge the valuable assistance of Ms. Deborah L. Rutman in the preparation of this section.

Interest in identifying and implementing community alternatives to institutionalization of the elderly has been strong among gerontologists for several decades. At present, while the majority of older persons continue to maintain their homes independently, there is a growing number of people who have opted to relocate to more protective settings, in which some combination of personal supervision, social services and health care is either routinely provided or is available upon request.

There is a great variation regarding the amount of protection or restrictiveness that noninstitutional housing environments for the elderly provide. At one end of the scale, for example, are retirement villages, which are especially utilized by more active and financially secure elderly. At the other end, there are group and family boarding homes, which provide both daily supervision and some medical services for the more frail and/or infirm aged. In general, all of these alternative housing programs share an emphasis on either inhome or community services for the aging resident, with the goal of forestalling or preventing inappropriate or premature institutionalization. A brief description of some of the more popular types of specially designed housing programs for older people follows.

Retirement Villages. This form of specialized housing for the elderly is the least restrictive insofar as it caters to the needs and preferences of the most mobile and healthy clientele. Retirement villages were first developed in the early 1960's and can be characterized as communities in which criteria for membership are primarily one's age and, to a certain extent, one's financial situation. Retirement villages, similar in concept to retirement hotels and trailer villages, are minimally supervised communities in which home maintenance is provided, and, because they are almost exclusively rental units, costs are relatively low. Nevertheless, residents of retirement villages tend to be middle to upper income older people, and are most frequently socially and ethnically homogeneous. (Hunter, 1973; Sherwood, 1975)

As with all community housing for older people, the number of medical and/or social services provided by retirement villages varies from site to site. Typically though, because residents are primarily younger persons who are active and physically able, social activities rather than medical services predominate. While not all retirement villages offer all of the following services, programs frequently include recreational activities, work opportunities, craft and religious clubs, and cultural and educational activities. Nursing or medical care is usually available only on an emergency basis, since most retirement villages feel that the provision of this type of care is beyond their jurisdiction on an ongoing basis. (Hunter, 1973) Retirement villages also vary in terms of the source of their funding. Although Federal or publicly supported retirement communities exist, the majority of these settings are financed either by religious or private organizations.

Congregate Care Homes. Congregate care homes have been described as "residential environments which incorporate shelter and services needed by tha functionally impaired and socially deprived but not ill elderly." (Hunter, 1978) Because congregate housing residents are primarily physically well older people, this form of housing for the elderly is one of the less sheltered environments along the "restrictiveness" continuum. Indeed, most congregate housing tenants would be capable of living independently in their own homes; they elect to live congregately because of the convenience, and because they feel congregate housing provides services which may become important if not indispensible in the future. (Kostick, 1978)

The variety of services which congregate housing provides is great, and ranges from age-segregated apartment buildings offering no additional services to homes providing a wide array of social and medical programs. Despite this range, congregate housing almost always includes some type of centralized dining service, and some type of housekeeping or chore service. In addition, nursing and medical staff are usually available daily, sometimes living on site. Social and recreational facilities are also usually present in varying degrees, and personal counseling is also available at some of the more fully serviced facilities. Finally, while almost all congregate homes provide private bedrooms and usually offer private baths, they vary in terms of the degree of furnishing of each unit, and whether they contain individual kitchens and living areas. (McFarland, 1976)

Funding for congregate housing can be either private or public. As the concept has increased in popularity, more federally financed or assisted buildings have come into existence, enabling low-income older people to become eligible for occupancy. In addition, many congregate homes are supported by religious or other charitable organizations, thereby reducing the costs to tenants. However, for nonsubsidized financed buildings, the costs of rental may be extremely high, preventing all but the most economically secure elderly from applying. (McFarland, 1976)

Boarding Homes. Boarding homes were originally established to provide inexpensive shelter to physically well older adults. Yet, while tenants usually entered boarding homes in reasonably good physical health, as they got older, their physical condition frequently deteriorated, significantly reducing their functioning capacity. In response to these needs, boarding homes began to offer a moderately wide range of medical services and nursing care, finally evolving into semiconvalescent homes for long-term occupancy. (Sherwood, 1975)

Boarding homes vary in terms of the number of clients they serve, ranging from 3 to 15 adults. Tenants have private, furnished rooms, but usually share a bathroom and take their meals in a communal dining area. While boarding homes sometimes provide some social and medical/nursing services, they also stress the use of community facilities for their clients, and supervisors generally try to encourage residents to be active. (Skellie and Coan, 1980)

Foster Home Care. While foster homes have long been used as an alternative living arrangement for children, it is only within the past several years that foster family care has been initiated for the elderly. Foster family homes can be distinguished from boarding homes in that they are under the jurisdiction of a governmental agency who pays the operator and sets and enforces standards and regulations. (Kraus et al., 1977)

Presently, almost all residents of foster family care programs are females; the majority are also widows, and nearly three quarters of them have come from either psychiatric or long-term care institutions. (Newman and Sherman, 1979) Foster homes provide for the care of up to five residents, and function most successfully when the number of tenants is held to a minimum. Foster homes are typically managed by a single operator or caretaker, whose responsibilities include food purchasing and preparation, housekeeping and varying degrees of personal and emotional care of clients. As was the case with boarding homes, residents are encouraged to use community facilities and to participate in neighborhood activities. A recent study found that after taking up residence in foster family homes, 75 percent of the clients had met their neighbors and had been involved with some community events. (Newman and Sherman, 1979)

While foster family care as an alternative housing environment for older people is still young, preliminary data suggest that it is a promising option for elderly persons in search of sheltered community care.

Group Homes. Of all of the forms of housing described thus far, the environment of the group home probably bears the closest similarity to a mini-institution. While the structure and organization of group homes vary, in general the operators have a greater impact on the lives and daily activities of their clients than do the caretakers of other forms of housing. (Kostick, 1978) Moreover, group homes serve a more physically disabled population than do the other types of specialized housing for the aged. Most of the tenants of group homes were institutionalized prior to their admission to these programs. (Kostick, 1978)

Like all of these alternative forms of housing for the elderly, group homes vary with regard to both the number of clients they shelter, and the nature of the services they provide. Because the clientele of group homes tend to be less active and mobile, there is usually greater attention directed to personal and health related care, rather than to social and recreational programs. In addition, group homes, especially smaller ones, tend to foster a considerable degree of restrictiveness and may inhibit independent behavior in its elderly clientele. (Sherwood, 1975)

Services Addressed to Socialization and Community Coping Skills

To facilitate the deinstitutionalized client's reintegration and adjustment in the community, services need to be provided that assist in the strengthening of social skills, self-confidence, and competencies in coping with the requirements of everyday life. Such programs can be either transitional or long term in nature, and can focus on interpersonal relationships, activities of daily living, personal growth and development, and/or recreational and leisure time activities. Whatever their emphasis, they are designed to provide support and acceptance to the individual and to ease his or her readjustment through a process of learning, rehearsing, and polishing the skills of social involvement and self-autonomy.

Resocialization Programs for the Mentally Ill

Resocialization programs and social clubs had their origins in England and the Soviet Union in the 1930's and were among the first psychosocial modalities developed in this country. The major growth of social clubs took place after 1960, as part of the reformation of the American mental health system that began to take shape at about that time.

Social clubs attempt to establish a climate that is supportive and democratic in nature. Writers have characterized their role and flavor in the following terms: "(Clubs have) therapeutic and rehabilitative effects that aid ex-patients over the transition from a hospital sub-culture to the community culture, a process fraught with potential cultural and personal discontinuities" (Landy and Singer, 1968, p. 133); as a place where the client can find needed acceptance, where problems can be freely discussed, support offered, interest evinced and acceptance assured (Barton, 1962); a sheltered environment in which the clients meets acceptance and the stigma of institutionalization is at a minimum . . . a place in which the client can test himself and the group, and develop behavioral patterns which will hasten his movement into the wider community (Wechsler, 1960); as a crucible of social learning, in which the client can utilize the responses of the other group members and staff as touchstones of social reality.(Rutman, 1965)

At the same time, there have been some questions and cautions raised about the net effectiveness of this type of program for former psychiatric patients. Hawxhurst and Walzer, for example, observe that some clients may see the club as an end in itself, that a steady diet of socializing and relaxing is inconsistent with the challenges of the real world and might reinforce the client's negative self image. (1970) Wechsler notes that participation in such

programs may hamper clients' development of new forms of self identification, and that, if this occurs, the club can become a permanent reference group rather than a socializing agent. (Wechsler, 1960) And Olshansky points out that the relationship between social functioning and work capability has never been determined, and that well developed social skills do not necessarily imply an improved readiness for work adjustment. (Olshansky, 1968) Notwithstanding the possibility that social clubs may be potentially limiting and do not represent a panacea for all problems, prevailing opinion and experience support the usefulness of socialization programs in reducing or overcoming the dependency and apathy that is so frequently exhibited by former mental patients.

As noted above, social clubs and centers offer activities of several types. These can be delineated into programs that provide informal social and recreational experiences, programs that focus on training in the functions of daily living, and programs that offer opportunities for self-growth and development. In practice, however, it is unusual to find a facility which restricts its offerings to just one of these categories. Rather, most programs make available a combination of forms of socializing experiences such that the client is encouraged to become involved in many styles and levels of social interaction.

Programs that focus on informal socializing and recreation are relaxed and low key in nature. They usually are established on a drop-in basis; clients may visit during the day or evening, for a few moments, several hours or the whole day. Typically, one finds card or board games in progress, an area for reading books and magazines, a music-listening room, table tennis or pool, a kitchen for snacks and coffee—and mostly, small groups of people simply chatting and relaxing with each other. Such clubs may be in operation every day and evening of the week or may be open only on a part-time basis. However, because evenings, weekends, and holidays are particularly lonely times for deinstitutionalized clients, most programs make a point of being available during at least some of these periods. A variety of social-recreational activities may be offered: dances, movies, group dinners, lectures, etc. Or, events may be arranged by staff to take place in the community: picnics, trips to nearby places of interest, hikes, bowling, attendance at sports events, and the like.

The second type of socializing program—training in the activities of daily living—is usually organized on a more structured basis. The emphasis in such programs is on aiding the client to learn and incorporate the practical skills needed to cope with living in society, such as cooking, shopping, money management, hygiene, nutrition, transportation, etc. To accomplish this, a classroom approach is often used, with staff serving as teachers and role models. In addition, practical experience with these functions is introduced into the training agenda whenever possible. So, for example, a group of clients may be asked to take responsibility for preparing a group dinner. This will entail planning the menu, budgeting costs, shopping at the supermarket, cooking, serving, and cleaning up. Staff assists in these functions as needed and is close at hand as the tasks are carried out. Larger psychosocial agencies may outfit small mock living units that contain the appropriate equipment and appliances (e.g., ranges, washers, dryers) on which clients can receive training and practice.

Another important daily living need faced by many clients is that of literacy training and further education. Some socialization programs, in cooperation with their local school systems, make arrangements for their clients to receive instruction in literacy and arithmetic skills and/or to take classes leading to a general equivalency (high school) diploma. These classes are often provided at the facility and may include persons from the community who also need such help but are not former psychiatric patients.

A number of skills-training methods and systems have been prepared by practitioners in this field. Spiegler and Agigian have designed an education-behavioral skills model that provides in-depth training in social and communications skills. (Spiegler and Agigian, 1977) A somewhat similar approach has been developed by Beidel and Bellack (not dated). The Florida Mental Health Institute has produced a series of some 15 curricula programs, by various

authors, in such areas as developing assertiveness skills, problem-solving skills and leisure time skills. (Florida Mental Health Institute, not dated)

The third area of social programming focuses on activities geared to personal growth and development. Again, a variety of activities may be offered: groups and classes in crafts, music, current events, dancing, creative writing, etc. They may be led by agency staff, by part-time instructors in the particular specialty or by volunteers. Sometimes the activities take place at the program site, sometimes in the community—at a "Y," church, adult education center, etc. Several large psychosocial centers (e.g., Fountain House in New York, Horizon House in Philadelphia, Thresholds in Chicago) also offer more extended activities such as camping, farming experiences, and white water rafting for their members. These special outings, up to a week in length, are arranged and conducted by program staff.

It should be stressed that no matter what the content of a particular activity or class, the underlying objective is to facilitate interaction and the growth of self-confidence on the part of the client. Socialization programs, although they may at times resemble adult education centers, are not primarily concerned with turning out artists, writers, or home economists. Rather, the activities offered are used as vehicles through which clients are helped to make friends, develop competencies, and acquire a sense of community belonging.

At present, there are an estimated 200 free-standing social club programs, under sponsorship of psychosocial centers, mental health and mental retardation associations, churches, and other social agency and community organizations. In addition, there are several hundred additional programs, more or less similar in approach, that are provided as part of local community mental health center services. Moreover, there is a network of perhaps 75 social clubs that are operated by ex-patient organizations on a self-help basis, one that by choice rejects professional supervision or involvement.

In many major United States cities there are psychosocial centers which offer a comprehensive set of services to psychiatrically disabled clients. Full time programs, they employ up to 100 staff members and provide most of the socialization programs described above as well as residential care (group homes and apartments) and prevocational and vocational services. Among the major facilities of this kind are Fountain House, Horizon House, and Thresholds (already noted); and Hill House in Cleveland, Portals House in Los Angeles, Fellowship House in Miami, and the Center Club in Boston. A more complete listing and fuller descriptions of the principles and services offered by such facilities have been prepared by Glasscote et al. (1971) and Robinault and Weisinger (1978).

Resocialization Programs for the Mentally Retarded

The socialization needs of deinstitutionalized mentally retarded clients follow closely those outlined for the psychiatrically disabled. There are, however, a few differences that should be noted. First, the emphasis with retarded persons is more often on their learning personal and interpersonal skills for the first time, than on relearning them. This is so because prior institutional care typically was not geared to providing training or instruction in independency functions, but rather to custodial supervision. Second, skill training and socialization activities for this group may need to be conducted at a slower pace and lower level than for psychiatric clients. Third, greater attention may need to be directed to more basic communications and daily activities skills, such as speech therapy, reading, hygiene and grooming, and learning to make change. Because of the heterogeneity of this group, some uncertainty exists regarding which community integration services are most required by retarded clients. Studies in this area are inconsistent; some indicate that personal counseling and health care are of greatest value (Mamula and Newman, 1973); others indicate that day treatment programs and behavior management training are most needed. (Scheerenberger, 1973; Wyngaarden et al., 1976)

There are fewer socialization programs and clubs serving the retarded than the psychiatri-

cally disabled. Counterparts in the retardation system to the community-based psychosocial centers such as Fountain House and Horizon House have been slow in developing. Most facilities offering socialization programs for this population are either free-standing or operated under the auspices of State developmental disabilities councils or State and local associations for retarded citizens. These latter organizations may be consulted for further information regarding the locations and service offerings of socialization programs.

One final note: lest the impression be inadvertently conveyed that resocialization programs for the retarded necessarily must be low level or routine, a special program developed by Irvin Segal, a Philadelphia-based social worker, should be mentioned. Segal arranges to take groups of retarded persons on extended trips and tours throughout the United States and the world. He accompanies them and sees to it that the travel experience is rewarding and enjoyable. This program has been in operation for several years and Segal reports no more difficulty in coordinating his tours for retarded clients than most commercial travel agents encounter for their usual clientele.

Community Socialization Programs for the Aged

Socialization services for the aged differ from those for the mentally ill and retarded in several respects. First, the primary objectives in providing such care to the elderly are in many respects geared to prevention—of physical and mental health deterioration, of loneliness, of anxieties about the future years, of declining feelings of dignity and self-worth. In this sense, such programs are not so much called upon to develop competencies in activities of daily living or strengthen interpersonal skills as they are to provide continued opportunities for companionship, meaningful use of leisure time, and maintenance of already established capacities for social interaction.

A second difference is that socialization programs for the aged function as a focal point in providing care for this population in a way that acts to reverse the sequence of the delivery of services. Whereas the mentally retarded and psychiatric disabled typically utilize such programs after their discharge from an institution, the elderly tend to use them when problems first arise. The social center is then able to perform several functions simultaneously: to give support and assurance, to gain more information about the problem troubling the individual, to perform appropriate screening techniques in assessing physical and psychological well being, to provide direct counseling aid, and to initiate referrals to other human services agencies in the community to deal with the basic problem.

The third difference is that social programs for the aged are more acceptable to the community and (perhaps partly for this reason) exist in far greater numbers than comparable programs for mentally disabled clients. In a national study of senior centers conducted by Leanse and Wagner for the National Council on the Aging in 1975, nearly 4,900 senior centers were identified across the country that offered a program directed to older adults that provided services at least once a week on a regularly scheduled basis and made available some form of educational, recreational, or social activity. Other social service agencies and organizations offering only occasional activities for this group were not included in the total. (Leanse and Wagner, 1975) Moreover, the 4,900 respondents almost surely represent a sizeable underestimation of the actual number of programs that are in operation throughout the country. An additional 12,880 senior programs were initially identified and surveyed, none of which are included in the 4,900. (About 3,400 of these did not provide programs at least once a week; the balance—some 9,480—did not choose to participate in the study.) It is likely, therefore, that the number of senior social centers in the United States that met the criteria noted may be estimated at about 7,000 to 8,000.

Of the senior centers surveyed, the following major types of programs were identified, based primarily on extensiveness of service: clubs—the least comprehensive form of program—which meet once or twice a week, typically offer only one or two services, and predominantly have no full-time, paid staff; senior centers, which offer more services than clubs, are open

more hours of the week, and employ more paid staff; and multipurpose centers, which provide three to five different areas of service, are available on or near a full-time basis, may have as many as 20 paid workers, and frequently operate multisite organizations. Of the sample of facilities included in the study, about 29 percent were identified as multipurpose centers, 22 percent as senior centers, and 48 percent as clubs. Further, about half the programs were operated by voluntary nonprofit organizations and most of the remainder were classified as public/governmental agencies. There were in addition a few for-profit organizations.

Services provided by senior centers are quite varied. The three major areas of programs are education, recreation, and information and referral, with counseling a close fourth. In addition, centers may also furnish one or more of the following: transportation, outreach, health care, friendly visiting, meals on wheels, creative activities such as arts and crafts, legal services, and leadership development training.

The characteristics of the clients who utilize these facilities are of interest. Over half are between the ages of 65 and 74, and nearly a quarter in the 75 to 84 range. Approximately three-quarters are women. The majority—about 50 to 60 percent of those who participate in the programs—are socially inactive and, for this group, involvement in the center is often the major, if not only, social outlet. (Leanse and Wagner, 1975)

A final issue should be noted. Partly because aged clients feel comfortable attending senior centers, partly because of the stigma attached to receiving mental health services at a community mental health center (CMHC), elderly persons tend to underutilize significantly CMHC programs. This has led to considerable concern on the part of program planners, since it suggests that aged individuals who may need and could benefit from mental health counseling are not willing to avail themselves of this form of help. Various solutions have been recommended: that CMHC's and senior centers coordinate their services more closely, that the two groups of agencies arrange to share staff and facilities, that CMHC workers receive special training to sensitize them to the unique problems and concerns of the aged, and that senior center staff be given training to help them understand and deal more effectively with the emotional and psychological needs of their clients. An in-depth examination of this problem and of the proposed solutions are presented in the Proceedings of a Conference on Issues in Mental Health and Aging. (U.S. Department of Health, Education, and Welfare, 1976)

Vocational Adjustment Services

In modern society, work serves many functions. It is a symbol of normality, a mark of maturity, the source of material and social gratifications. Moreover, occupational status tends to define the individual's self esteem and identity. These qualities associated with the role of worker underscore the key importance of developing programs designed to assist deinstitutionalized clients prepare for, secure, and retain jobs as part of their community readjustment experience.

The task, however, is by no means easy. To begin with, many deinstitutionalized clients often exhibit poor job skills, inadequate training, spotty work histories, and unrealistic aspirations. Next, these clients' motivation to work may be weak, especially if they are receiving some form of societal support, such as public assistance, SSI, Social Security disability, or Veteran's disability pensions. Persons in this position are faced with the difficult dilemma of being asked to relinquish assured support in favor of employment that (1) may yield them little if any additional net income, and (2) may be of short-term duration. Understandably, many clients in these circumstances opt not to jeopardize their welfare or disability income. Next, employers often react negatively to the notion of hiring mentally disabled or formerly incarcerated persons and resist accepting them into the work setting. Finally, since many of the jobs for which deinstitutionalized clients are qualified are at low or entry levels, clients must compete with nondisabled persons seeking the same kinds of work. Given prevailing unemployment rates in the general population of about 7 to 9 percent (and much higher for youths, blacks,

and other minority groups), job opportunities for deinstitutionalized clients thus become all the more problematic.

To aid deinstitutionalized persons' return to the work world, five major types of vocationally oriented programs may be utilized. These are: predischarge training, community-based workshops, transitional employment, job finding and job placement, and followup programs. On the following pages, each of these will be briefly reviewed in relation to their objectives, methods, and utilization with the various disability groups.

Predischarge Training Programs

Predischarge programs attempt to prepare clients for a productive job role through training, participation in workshops, job counseling, and/or trial employment while the individual is still in the institution. Many of these programs are limited in scope, consisting almost entirely of inmate worker programs (often referred to as work therapy) or institutionally based shelter workshops, while others are quite comprehensive and may include vocational evaluation, training, and actual employment.

Inmate-worker (or work therapy) programs—still a frequently encountered modality—have operated under the rationale that work is inherently therapeutic for the individual. Until relatively recently, however, many of the tasks performed under such programs were accompanied by little if any financial remuneration for the worker. The Souder vs. Brennan decision of the U.S. District Court in 1973 drastically altered that situation. The court was sympathetic to the argument that a major amount of work done under so-called work therapy programs was menial and repetitive in nature, and was inspired more by the economic necessities involved in operating the institution than by therapeutic principles. The decision, rendered on behalf of State mental hospital patients, held that patient-workers must be treated in accordance with the Fair Employment Standards Act with respect to minimum wage and working conditions. The impact of this decision on what has been referred to as "institutional peonage" is more fully discussed by Safier (1976) and Stockton (1974).

Work-therapy programs aside, a number of innovative programs for institutionalized psychiatric patients have been designed and demonstrated. As described by Robinault and Weisinger (1978), they include:

- A project conducted in the early 1960's in a Georgia State mental hospital, developed through the collaboration of the hospital and the State vocational rehabilitation agency. Under this program, inpatients were given work evaluation, vocational training, counseling, placement, and followup services. The results of this demonstration project showed that 78 percent of the group who received such services were either employed or in training after discharge, compared with 35 percent of a control group. Moreover, more than twice as many program participants reported positive job satisfaction than did the controls. (Jarrell, 1964)
- At the Florida State Hospital in Chattahoochie, patients are given basic literacy and high school equivalency courses as well as vocational training to facilitate their adjustment to life outside the institution. Trainees attend classes four days a week for a total of 12 hours. Vocational training is offered in food services, carpentry, sales, home economics, and small-engine repair. The various education/training courses utilize 14 teachers, half of whom are assigned to the project by local school systems. The classes are open-entry, designed to proceed at the clients' own pace, and individualized with respect to participants' social and interpersonal needs. (Florida State Hospital, 1975)
- Patients are hired as staff workers, performing such jobs as librarian, custodian, barber and beauty shop assistants, food handlers, and nursing assistant in a program developed at the Mental Health Institute, a small state hospital in Mt. Pleasant, Iowa. The emphasis is on vocational evaluation and work adjustment, and for these purposes some 60 job slots in 23 different positions have been created. To safeguard against the client's becoming too entrenched in the job assignment, a limit of 60 days is placed on each individual's participa-

tion. Patients work no more than 20 hours per week, are paid at a percentage of the prevailing minimum wage for the position, and have their wages adjusted every 2 weeks based on their performance. (Foote and Wilson, 1976)

- Operation Gas Station, developed at Elgin State Hospital in Elgin, Illinois, combines vocational training and on-the-job work experience for its participants. Hospitalized patients are evaluated for their ability to perform regular service station tasks and are trained by experienced station attendants who are hired for this purpose. Trainees are then assigned to work at gas stations off hospital grounds, where their performance is supervised and monitored by the same trainers. Considered a sheltered workshop, the program falls under Department of Labor certification standards; clients are compensated according to sheltered workshop rates. Continuing followup meetings are held with patients to review work experiences and encourage the development of positive work habits and attitudes. (Arantunian et al., 1976)

Institutional-based, predischarge programs serving criminal justice clients tend to be less diverse, less comprehensive, and probably less effective. Data show that the vocational problems of this population are severe: less than one-third of those who receive training while in prison use it in their first postrelease job; the majority of men leaving prison had no prearranged job; unemployment rates among released Federal prisoners are between three and five times greater than for the comparable civilian labor force. (Pownall, 1975) Three issues are of major concern in this connection. First, most predischarge training programs are directed to juvenile rather than adult offenders, exacerbating even further the problems of the latter group. Second, continuity of services between institutional training programs and postdischarge counseling and placement functions are generally inadequate. Third, the predischarge training programs for this population are themselves typically limited both in scope and applicability to outside job opportunities. For the most part, they serve primarily to assist in the routine operations of the institution rather than provide work experiences and a social climate comparable to those found in regular competitive work settings. (Pownall, 1975)

A strategy that attempts to address these concerns is the work release plan for offenders. Under this arrangement, an individual sentenced to prison is permitted to work for pay in the outside community, but returns to the institution during his nonworking hours. Work release thus falls somewhere between probation, parole, and confinement, insofar as it provides the person with greater opportunity to pursue social and vocational rehabilitation directions, yet continues his status—and supervision—as that of a prisoner during his off-work hours. For a fuller discussion of work release programs, see Johnson. (1975)

Community-Based Workshops

The most widely used approach to fostering the development of vocational capabilities is the community-based workshop. First originated nearly 150 years ago to serve the physically disabled, workshops grew gradually until after World War I, then expanded quickly following the passage in 1920 of the first Federal Vocational Rehabilitation legislation. In 1954, amendments to this legislation created significant new rehabilitation services for the mentally retarded and psychiatrically disabled. Since that time, workshops have continued to grow steadily, particularly those serving these two populations. As of 1974, the number of workshops throughout the United States that were certificated by the Department of Labor was about 2,700—an increase of over 100 percent since 1969. (Greenleigh Associates, 1975) Of this number, a substantial number serve the mentally disabled, either solely or primarily. According to the authors, "The individual most likely to be found in a sheltered workshop is a person with a mental or emotional disorder or mental retardation. Mental retardation is the primary disability for 53 percent of the clients studied and mental illness for another 19 percent." (Greenleigh Associates 1975, p. 54)

There are several types of workshops serving the disabled. Though different in structure and emphasis, they have in common the central theme of providing an opportunity for the perfor-

mance of productive tasks by handicapped workers for which the workers receive some financial compensation. These types include regular workshops, which provide a certificated wage rate of not less than 50 percent of the minimum wage and work activity centers designed for severely impaired clients whose production capabilities are extremely low. Work activity centers are not required to pay a fixed percentage of the minimum wage; evaluation and training centers which use a variety of standardized evaluation systems to assess clients' skills, work habits, physical and psychological capabilities, attitudes, and motivation. Although these centers offer no minimum wage guarantees, they are growing at the fastest rate, despite the fact that production output and client wages are both low. Evaluation centers are used especially in serving the mentally retarded.

Workshops may serve a mixed client population or may be designed for a specific disability group, such as victims of cerebral palsy, victims of blind, the retarded, or the psychiatrically disabled. They may operate as extended-care (or terminal) facilities or as short-term transitional settings. Over 80 percent are established as private, nonprofit agencies with the remainder primarily under the auspices of Federal, State, or local government. (Greenleigh, 1975)

Although workshop programs are well established and widely distributed, there is considerable disagreement regarding their effectiveness with disabled clients. Few question that their potential to be helpful is high; a Department of Labor study, for example, points out that they "operate in the dual capacity of preparing the less severely handicapped worker for competitive employment as well as providing long-term sheltered employment and supportive services for the more severely handicapped who are not likely to function independently in the community." (Kelly and Stephens, 1978) Olshansky observes that workshops help clients learn skills, earn money, develop a more effective work personality, and carry over to future jobs useful work habits learned at the workshop. (Olshansky, 1960)

On the other hand, many observers see serious limitations (if not actually counterproductive outcomes) in workshop services as they are often implemented. Pomerantz and Marholin (1980) raise a number of significant criticisms of workshops serving the mentally retarded noting that some of these workshops: (1) fail to place into competitive employment the great majority of clients; (2) fail to provide work tasks that are nonnormative and nonrehabilitative and that teach clients enough marketable, transferable skills; (3) are not organized or staffed to employ present-day business practices or furnished with modern equipment to enable adequate production output; and, (4) fail to meet production schedules and revenue-generating demands, tend to hold on to clients who function at a relatively high level rather than place them in competitive employment. In discussing workshops for psychiatrically disabled persons, Black cautions—despite a generally favorable view toward such programs—that workshop services by themselves are often of limited usefulness. He further notes the inherent tension that may be created in such programs by the conflicting objectives of rehabilitating clients and meeting production schedules. He observes that clients who are ready to take competitive jobs often do not need workshops, and those who are not ready derive only limited gains from them. (Black, 1964)

Comprehensive studies of workshop programs tend to confirm both the potential advantages and the existing limitations of these services. The issues of inadequate funding, outmoded facilities and equipment, and undertrained staff, and the need for subsidies for both workshops and clients are discussed indepth by Greenleigh Associates (1975), U.S. Department of Labor (1977), and the Urban Institute Report (1975). For descriptions of a number of diverse and interesting models of community-based sheltered workshop programs, see Robinault and Weisinger (1975).

Transitional Employment

During the past decade, transitional employment has become one of the most popular approaches serving the vocational needs of disabled clients. Transitional employment is designed to enable persons who are not fully job ready to enter the work world on a realistic,

fully remunerated basis. The approach generally proceeds as follows: a vocational or psychosocial agency arranges with a local business or industry to secure a given number (usually one to six) of job openings on a permanent basis, to be filled by the agency's clients. Usually these are entry level positions that do not require extensive amounts of skill or training. Clients are trained to do the work—either on the job or at the agency prior to beginning work—by staff or by other clients. The client is then assigned to the job, usually on a half-time basis, with the understanding that he or she will fill that position for a 6- or 9-month period. Wages are at the regular rate normally paid by the company for that position. After the client has worked for the designated period of time, he or she leaves (ideally to seek a regular full-time job elsewhere) and the vacancy is filled by another client from the agency's rolls, again on a part-time, time-limited basis.

Transitional employment offers a number of clear advantages to both clients and employers. It places clients in a real job, in the actual work world, there to earn at least the minimum wage. It helps them develop useful work habits and expectations while at the same time building a job record of real work experience. It permits them to avoid the problems of negotiating personnel procedures and obstacles, such as application forms, interviews and employer bias, that otherwise might screen them out of the employment picture. Since the jobs are usually part-time, it gives the client the opportunity to receive needed support and additional psychosocial rehabilitation services. Finally, if the transitional employment arrangement calls for several positions to be filled at one worksite, it provides clients with the additional support of working with others they already know and with whom they feel comfortable.

For the employer, transitional employment has several counterpart benefits. First, it may provide the employer with a Federal tax credit based on hiring a disabled worker. Next, it relieves the problems and expenses of recruiting and training workers in job areas that often are difficult to fill and/or have high rates of turnover. Next, the employer is assured of a dependable source of referrals of clients trained and motivated to handle the position. Further, the agency assures that the job will be filled every day; if the designated client cannot, for whatever reason, report to work on a given day, someone else—another client or if necessary an agency staff member—will be sent to cover the job.

Transitional employment programs are currently being operated by over a hundred vocational and psychosocial agencies across the nation. Originally developed to serve the psychiatrically disabled, the approach is being adapted to meet the needs of the mentally retarded as well. For this population, transitional employment styled placements are sometimes referred to as *enclaves*.

It should be noted that transitional employment programs are considered part of a larger vocational program called Projects With Industry which is supported by the Rehabilitation Services Administration of the Federal Government. According to Adams (1976) more than 500 businesses and corporations are cooperating in this program, accounting for over 2,000 jobs and client earnings of over $10 million per year.

Although minor variations are sometimes found, nearly all transitional employment programs operate along the lines described above. They are offered by a variety of facilities including hospitals, community-based workshops, and community mental health centers, in addition to the aforementioned vocational and psychosocial agencies. Further descriptions of specific program models are found in Beard (1976), Lichter (1978), and Williams (1973).

Job Finding and Job Placement

Traditionally, competitive employment has been viewed as the most desired objective and outcome for disabled clients. Although, as discussed earlier, a variety of problems act to impede this outcome, the personal, financial, and psychological benefits to the individual that result from obtaining a regular job are clearly most positive. Not surprisingly, then, many approaches have been developed to facilitate the job placement process. Some of these focus

on preparing the client to seek work opportunities more effectively, others are directed at working with employers to develop suitable positions within the company, and still others are aimed at overcoming employer resistance to hiring workers from the ranks of deinstitutionalized clients.

Programs that focus on assisting clients to improve their job-finding skills tend to leave to the client the decisions regarding whether to disclose prior institutional histories and how much of this information should be divulged. Although most professionals are inclined to favor the client's informing the prospective employer of the pertinent background data, they ultimately leave those decisions to the individual. When, on the other hand, placement contacts with employers are made by agency staff on behalf of clients, it is commonplace for some level of information sharing about the client's background to take place.

Many deinstitutionalized clients experience difficulty in negotiating, in all its aspects, the job-finding process. They are often anxious or inept with respect to many aspects of finding work, such as obtaining job leads, filling out application forms, preparing resumes, and learning how to present themselves and their capabilities in the most favorable light. To overcome these difficulties, programs have been developed which provide preplacement training in the job search process. A leading contributor to this area is Azrin, who helped pioneer the development of job-finding clubs for disabled persons (1975). These clubs combine counseling with practical suggestions and tips on where and how to unearth job leads and how to prepare for and rehearse the various processes associated with obtaining a job. The club format has the further advantage providing clients with peer support and encouragement and is utilized for this purpose by clients who continue to meet with the group even after they have successfully found employment. Horizon House in Philadelphia operates a preplacement training program modeled along the lines suggested by Azrin. As described by Kaufman,

> The Horizon House job search workshop includes all job-ready clients who are actively engaged in the job search process. Every morning at 8:30 a.m., the group assembles and together screens the daily classified advertisements for themselves and each other. Phone calls to prospective employers are completed from within the group; daily job search assignments are given to each group member; and reports of progress, both successful and unsuccessful, are discussed collectively. In addition to obvious advantages for the client, utilization of such a workshop also allows the placement specialist's tasks to become more efficiently focused. (Kaufman, 1977)

The other side of the job placement coin is job development, which takes the form of agency staff's contacting employers to search out openings for job-ready clients. Typically this is done on a selective basis; that is, the job developer tailors his inquiries to the particular skills, interests, and characteristics of a given client. If a "match" can be made to an existing vacancy, the staff worker encourages the employer to consider the client as a candidate. If no such job is currently available, the placement worker attempts to negotiate with the employer to modify or adapt the specifications of a similar job to the special capabilities and background of the given client, and to consider hiring him or her on that basis. Job development efforts also include the assurance to the employer that the staff worker or agency will remain in contact with both the client and employer after placement to assist with any problem-solving counseling or consultation that may be needed by either. Further descriptions of job development and job placement approaches are found in Rubin (1976) and Searles and Steinberg (1968).

Followup Services

Helping the deinstitutionalized client prepare for and find employment is only part of the battle; no less important are programs designed to assist the individual to maintain his job and adjust satisfactorily to any attendant personal or work pressures that may arise. Programs addressing the followup phase go by various names, including follow-along, postemployment services, community support groups, and job stabilization.

The importance of this area of service has only recently become recognized. Postemployment services were first alluded to in the 1967 amendments to the Vocational Rehabilitation legislation, then strengthened in the 1973 Rehabilitation Act. Such services are viewed by RSA as an integral part of each client's rehabilitation program and are now mandated as a required program component under the State-Federal vocational rehabilitation system.

Central to the notion of follow-along programming is the provision of the range of services necessary to maintain the client on the job. It takes into account the special personal and social supports the person may need as well as any needs the employer may experience. It is an area that cuts across disability groups in that such services are of equally critical importance to the retarded, the psychiatrically disabled, and criminal justice system offenders.

A number of interventions and models have been devised to address this concern. At a minimum, placed clients are requested to stay in some form of regular contact with their counselor or agency in order to discuss problems that may be emerging. Another format calls for groups of clients to meet regularly, either at the agency, at a client's home or in the community, to review work-related issues, and to benefit from each others' support and insights. In some programs (e.g., the Horizon House approach as described by Kaufman, 1977) group meetings are not only insisted upon for each newly placed client but outreach centers in the community are established specifically for this purpose. Finally, some programs are organized such that follow along services become viewed as the focal point around which the client's total network of community adjustment needs—personal support, medical, residential, legal, and financial—are identified and acted upon. Further reviews of principles and operations of various postplacement follow-along models are presented by Sands and Radin (1978); DuRand (1973); Shrey (1976); and Robinault and Weisinger (1978).

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VI. Issues in Manpower Development and Training

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Introduction

The quality of care offered by human service workers attempting to meet the social, residential, vocational, and personal/emotional needs of the deinstitutionalized is uneven. As deinstitutionalization programs have expanded, manpower planners have recognized that many human service workers require upgrading and retraining in order to meet the needs of their special populations. It also has become apparent that academic curricula for preparing professionals and paraprofessionals do not adequately address the tasks associated with deinstitutionalization programming.

Human services work is, of course, labor intensive. Eighty percent or more of its resources are personnel resources (Smith, 1979), and with this concentration comes several problems. First, there is currently an inadequate supply of manpower specifically trained to work effectively in direct service capacities with deinstitutionalized populations. Second, human service providers utilize nonstandard and discrepant definitions of the community-based service activities they provide, making accurate manpower data and projections relatively unavailable. Third, in the face of decreased funding, improvements in the delivery of human services may only be achieved through the development of new and better skills in the work force.

To date, there have been quite a few solutions developed to alleviate these concerns. Most assessments of manpower technologies tend to agree that despite the strong need for valid and reliable methodologies in this field, currently available approaches have substantial limitations. (Browkowski and Smith, 1974; ADAMHA, 1978; Schulberg and Baker, 1975) Sobey's (1979) statement of a decade ago is probably still on target: "Manpower theory today is reported to be a nebulous grouping of unsystematized conceptualizations."

The concerns surrounding projecting manpower needs, and thus training needs, have several dimensions. For example, planners concerned with establishing manpower needs must distinguish between need and demand. (USDHEW, 1976) This seems particularly important for the mentally ill, physically disabled, and aged in that many of these persons, judged to need services, are either not motivated to seek them or actively reject them. And this issue becomes intensified when the outreach function of workers creates additional demands for services. Another concern stems from rigid or antiquated manpower policies at the state level which add to the complexity of the problem insofar as they discourage or preclude effective (and flexible) utilization of human services manpower. Schulberg and Baker (1975) observe:

There is little need to emphasize the crucial implications to human services of wise decisions about personnel selection and deployment. Manpower and training costs consume the greatest part of most human service budgets, and administrators strive to minimize waste and optimize the use of high-priced professionals. However, this effort generally is impeded by intra- and extra-organizational constraints which limit the design of innovative approaches and reinforce antiquated patterns.

From the planners' perspective, then, it is important to view deinstitutionalization services as part of a comprehensive human services industry. A rational structure for identifying service goals and undertaking manpower planning associated with community-based services is needed, one in which the needs of clients, providers, and institutions are balanced and coordinated. (Smith, 1979) In such a structure, workforce requirements and manpower policies should be designed to meet preestablished service objectives; barriers to accomplishing effective manpower development and deployment should be identified (e.g., legislation, budget restrictions, political structures, unions, professional self interests, community attitudes); and strategies to deal with these barriers should be formulated.

These issues are especially critical to manpower concerns in the deinstitutionalization field, in which an expanding workforce with ill-defined service responsibilities and little professional cohesion bears major responsibility for implementing community-based programs.

Emerging Manpower Trends

In the past several decades, there have been dramatic changes in many aspects of the philosophy, structure, and focus of human services delivery systems. The present array of human service personnel providing community-based services has evolved from the numerous shifts of the last 30 years that have been described in other chapters of this monograph. In the mental health field, deinstitutionalization followed the introduction of the psychotropic medications, the development of community mental health centers, and a series of landmark legal decisions which expanded and safeguarded patients' rights. Later emphases on prevention and rehabilitation services and additional Federal programs in alcohol and drug abuse also heightened the focus on deinstitutionalized clients, and made necessary not only an expanded workforce, but also one with special and relevant skills.

Institutions for the mentally retarded also began to move toward rehabilitation and education programs in the context of preparing their residents to live independently in the community. Concurrently, a variety of community-based social and residential programs for the retarded were developed. These programs, stressing behavioral and educational approaches, accentuated the need for staff workers oriented to a different treatment philosophy and armed with specific competency-building technologies.

Generally, similar developments occurred in the criminal justice system in the later 1960's, spurred by an increased emphasis on treatment for alcohol and drug abusing individuals as an alternative for incarceration; thus, juvenile offenders were more often left with their families and given treatment in the community, and community-based programs enabled many adult offenders to participate in work release and job training activities.

Community rehabilitation also became a major treatment thrust for persons with physical disabilities. The Civil Rights Act of 1964 paved the way for the Rehabilitation Act of 1973, which made work a right for the physically disabled, among other groups. At the same time, the quality of rehabilitation was expanded so that needs other than employment were afforded new importance.

These changes toward community-based services, independent social living and client self-determination each underscored the need for new staffing patterns and new staff competencies. However, manpower issues have continued to be viewed, for the most part, from the

perspective of supply of workers (often in relation to formal credentials), rather than from the perspective of roles and interdisciplinary relationships. This led to misunderstandings among the professional disciplines and staff workers. One source of such misunderstandings stems from the fact that many human service programs (e.g., family, children and youth services, public health, mental health and retardation, alcoholism and drug abuse, aging, criminal justice, vocational rehabilitation) share similar goals, use many of the same kinds of personnel, and are likely to be funded by the same public funds. As the number of staff workers in human service facilities has increased, some policy-forming groups, including the President's Commission on Mental Health (1978) and the ADAMHA Manpower Policy Analysis Task Force (1978), have recommended a decrease in emphasis on the supply of manpower and greater attention given to the utilization, staffing patterns and effectiveness of such personnel. In this connection, the President's Commission on Mental Health established as a central goal "to assure that the skills and knowledge of mental health personnel are appropriate to the needs of those they serve." This concern with competence, regardless of discipline or degree, constitutes a major manpower and training thrust of the human services field. Deriving from this perspective, several identifiable trends regarding manpower needs have emerged, the most important of which have been: 1) the tendency to structure generic staff roles; (2) the rapid proliferation of paraprofessionals; (3) the utilization of varied staffing patterns; and (4) recognition of the growing problem of role confusion and staff burnout.

Generic Staff Roles

The Southern Regional Education Board has identified three major developments that have moved community programs toward adopting generic roles for their workers.

- The relationship and roles among the core professions (medicine, psychology, social work, nursing) have greatly changed. The medical model has been joined, and sometimes replaced, by social and learning models in many community-based treatment facilities. The growth of psychosocial rehabilitation approaches has brought about a blurring of role functions among the professions, primarily because members of each of the core disciplines may play similar, significant roles in the treatment of the deinstitutionalized in a given community setting. Thus, workers from each profession may at times perform leadership and staff roles in both administrative and direct service areas, demonstrating a functional interchangeability almost entirely unknown within traditional institutional settings.
- There has been an increase in the kinds of professions serving the human services field. In addition to the core disciplines, other staff members specializing in the problems of aging, rehabilitation, drug and alcohol and correctional system populations have been added to the personnel ranks of community service providers. Many have been trained in such fields as special education, sociology, and pastoral counseling rather than the traditional health professional fields. Although such workers for the most part have been considered ancillary personnel, they comprise nearly 12 percent of the direct patient care staff (Taube, 1976) and have assumed increasing authority in their roles.
- New levels of human service workers have been introduced. With the expansion of social programs in the 1960's, manpower shortages led to the development of innovative utilization of human service workers possessing fewer formal credentials than traditionally trained staff. It has been estimated that there are from 800,000 to two million paraprofessionals involved in human service programs in the United States. (Gage et al., 1977)

As a consequence, staff roles have been gradually reshaped and redefined. Role functions and relationships previously accepted have often been revised in favor of more flexible patterns for responding to client needs in community settings, with the implicit recognition that each worker may be called upon to fulfill a variety of functions—counselor, therapist, case manager, advocate—in his or her work with clients.

The Paraprofessional Movement

As recently as the late 1950's, only the core professions were involved in the provision of mental health services. The prominence of these professions was fostered by substantial government support to professional schools in university settings. Although this resulted in substantial growth for these disciplines, shortages of direct service staff still existed as a major problem. In 1959, Albee stated that manpower shortages would never be alleviated if the only course of action were to continue training and utilizing professionals in the traditional ways. (Albee, 1959) Albee's views were heard. Experiments in the development of new types of workers were begun in the 1960's. A number of different approaches—such as Rioch's demonstration that mature women could be trained in two years as effective psychotherapists under supervision (Rioch 1971)—were explored. From these efforts emerged the development of a paraprofessional workforce.

The recognition that the professional disciplines could not be expected to provide all the services needed by clients led to the creation reaction within the Department of Labor of a New Careers Paraprofessional training program. Developed through Model Cities and the Office of Economic Opportunity programs, it was initiated to train entry level workers for a wide range of human service programs. (Levine et al., 1979) The combined impact of the Economic Opportunity Act, the Health Manpower Development Act and the Civil Rights Act has a major influence on many health and social programs, both by increasing the size of the population to be served and by creating a demand for personnel to be drawn from the same socioeconomic environment as those served. Underlying the latter development was the premise that workers would be more empathic to clients when both shared similar life experiences. This orientation was given further impetus by the recessions of the 1970's, the effects of which were to encourage the hiring of substantial numbers of new workers through funds made available by Department of Labor Manpower programs, the Economic Opportunity Act and later the Comprehensive Employment and Training Act (CETA).

Paraprofessionals have been employed in a large variety of institutional and community-based human service programs. Young et al. (1976) in a study of 106 human service workers with associate degrees, identified activities that were performed frequently by more than 50 percent of them. These tasks include: conducting intake interviews, gathering information on client's immediate life situation; recording history and background information; making recommendations for treatment, discharge, followup; doing individual counseling; motivating clients; carrying out milieu therapy; working with client's families; keeping client records; participating in staff/team meetings; scheduling appointments; serving as spokespersons or advocates for clients in relation to treatment staff; helping clients obtain legal, financial or other assistance.

Further results of this study disclosed that supervisors rated 70 percent of the workers as "excellent or good," and in the direct care activities 90 percent or more of the workers were rated as "satisfactory" or higher. Confirmation of paraprofessionals' effective performance has been reported in numerous other studies. (Steinberg et al., 1976; Alley and Blaunton, 1976; Fenton et al. 1974; Dorgan and Gerhard 1977; Albee, 1968) As a group, these findings attest to the significant contribution that paraprofessionals make to the human service field. As Alley and Blaunton (1978) state, "paraprofessionals have been crucial to the provision of new and innovative services which are usually not provided by the traditional professionals."

Varied Staffing Patterns

With limited budgets, it is important to know the services workers can perform, their supervisory needs, and the methods of training needed to prepare them to perform these tasks. These elements, in turn, will be influenced by the organizational structure of a given facility as well as its readiness to employ unorthodox or innovative patterns of utilizing its staff members. Many smaller service agencies, for example, that provide community-based re-

habilitative services to particular deinstitutionalized disability groups (notably drug abusers, alcoholics and former prisoners) favor the employment of former clients in various staff capacities. In these types of settings, staff roles and functions are established not on the basis of job title or credentials, but rather by such factors as the quality of the worker's relationship or his or her effectiveness or communication with the client.

Another area of growing interest centers on the relative advantages of having a worker function as a generalist in relation to the needs of a given disability group, as opposed to having the person serve as a specialist for a particular area of adjustment (e.g., therapist or job developer). In general, although no consensus yet exists, current thinking favors the generalist approach, partly as a reaction against past categorical structures in the delivery of services, partly because of the belief that providing helping services is a generic process.

The following more or less prototypical patterns of staff roles and utilzation, described by SREB (1979), can be observed in different types of human service settings. The more formal functional and hierarchial relationships tend to be found in institutional settings, while agencies providing community-based programs for the deinstitutionalized have staffing patterns which tend to be more nontraditional in nature.

- Institutional programs - Roles and hierarchies in institutional settings tend to be clearly defined and career advancement is dependent mainly on years of tenure and experience. Professionals perform traditional roles and paraprofessionals serve as aides who assume secondary tasks and perform routinized tasks and procedures.
- Community mental health/mental retardation centers - In these settings there is often a discernable emphasis on professionalism, with treatment responsibility reserved for staff educated at or beyond the master's level. Paraprofessionals ordinarily are not permitted to carry an independent caseload. Rather, they perform less demanding tasks such as maintaining medication and appointment schedules, contacting absent group members and recording case record data.
- Specialized treatment units - These programs, often small satellite facilities attached to a larger treatment center, work with a particular population such as the aged, mentally retarded persons, or drug and alcohol abusers. Professionals usually have the administrative function and paraprofessionals a generalist role, with both levels of staff working as a treatment team.
- Psychosocial rehabilitation agencies - These programs are likely to work with more noticeably dependent and dysfunctional psychiatric clients. There is considerable role blurring at psychosocial centers, with paraprofessionals usually serving as generalists, a tendency which Glasscote (1971) and Lanoil and Turner (1979) see as a particularly distinctive aspect of such agencies. Dincin (1975) observes that "in most (psychosocial) agencies the staff play interchanging roles. Case workers do group work, vocational counselors do case work and psychologists do job placements." Interestingly, less highly trained workers are often found to reflect the highest levels of optimism for client improvement in these types of settings.
- Group homes and foster homes - Professionals are usually not available to do home visiting, so paraprofessionals are used extensively in such facilities. Populations most often served by these programs are the mentally retarded, the aged, adult offenders and substance abusers. Halfway houses and related residential programs in the community also frequently employ paraprofessionals who live in and perform the role of houseparents.

Staff Burnout

Within the past several years, the issue of staff burnout has been catapulted into the human services field and quickly captured the attention of administrators and staff workers in virtually all types of settings. In quick order, dozens of articles appeared that sought to conceptualize, define, explain, measure, or alleviate the problem. While the notion remains controversial—

some observers doubt that it is a meaningful condition or area of study, while others regard it as one of the most pressing concerns in the human services arena—it cannot be ignored. It has generated so much interest that its existence is accepted widely by human services personnel.

Numerous reasons have been offered to explain the low morale, the reduced motivation, the loss in enthusiasm experienced by human service workers, particularly those in deinstitutionalization programs. Some observers ascribe it to various changes in attitude and behavior that occur in response to difficult-to-accomplish agency objectives. Maslach (1976), who characterized burnout as the "loss of concern for the people with whom one is working," is one of many writers who believe that burnout is caused by external or organizational pressures. Others have proposed that burnout occurs because of changes in motivation, resulting in feelings of alienation from clients, co-workers, and agency, and leading to a psychological withdrawal from work (e.g., Freudengerger, 1975). Still others believe that the origins of burnout are to be found in intrinsic causes. Cherniss (1980) suggests that burnout is a transactional process, involving an imbalance between personal resources and job demand: This then leads to short-term adverse emotional responses such as feelings of anxiety, tension and fatigue, and finally results in persistent negative changes in attitude and behavior; for example, a tendency to treat clients in a detached, perfunctory manner, or a preoccupation with one's own needs. This model is similar to the four stages of burnout described by Eldwich (1980): (1) enthusiasm; (2) stagnation; (3) frustration; and (4) apathy.

The effects of burnout on staff members can be extreme, especially in community-based programs in which client well-being is often a direct function of ongoing staff effort. Paraprofessionals who provide direct services to deinstitutionalized populations are faced with unusually high job expectations and demands. They are asked to devote personal commitment such as a "deep-seated investment in all areas of the member's (i.e., clients) life situation" (Dincin, 1975) as well as a sense of responsibility to a wide range of job functions related to client needs. Most paraprofessional workers have received relatively little training for their roles. Consequently, these pressures, when coupled with devaluation by professionals and low pay, often lead to high staff turnover and low morale.

Professionals, on the other hand, may experience the burnout phenomenon as an indirect result of their specialized training. They have acquired a demonstrable level of expertise as a result of such training and often have been oriented to play a discipline-specific role. Although there has been little preparation for these professionals to practice interdisciplinary service delivery, the realistic demands of their work often require a team-treatment approach which creates a blurring of roles between paraprofessionals and professionals and among professionals themselves.

Lieberman (1979) reports that professionals trained in providing direct care services express feelings of being "overwhelmed" by undertrained clinical staff. A recent study of a human service agency cited a variety of programmatic frustrations that negatively affected the role and functions of professional staff members:

> Uncertainty regarding scope of authority, responsibility and accountability were consistently referenced as problems. Role ambiguity was most apparent in relationships between district program supervisors and network personnel ... Concern was often expressed in terms of having too many supervisors who were not making good decisions due to lack of program expertise. (Whitman 1979)

Effects of Burnout on Job Performance

Research on stress management suggests that job stress has an adverse effect on a staff member's performance even before it leads to maladaptive attitudes towards clients and work (McGrath 1970). For more complex, ambiguous tasks, even relatively low levels of stress are disruptive. And if the stress persists for any period of time, the individual is likely to become demoralized and unlikely to develop effective problem solving approaches (Lazarus and Saunier, 1978). Because much of the work that is done by human services staff involves

complex problem solving, it can be predicted that beyond very minimal levels, job stress will adversely affect job performance.

Emotional detachment and withdrawal, cynical attitudes towards clients and administration, rigidity and resistance to change, and preoccupation with one's welfare are easily transferred from individuals to an entire group within an organization. For example, the antitherapeutic and custodial norms that characterize the institutional culture are thought to have developed as a collective adaptation to job stress and organization powerlessness. (Allen, et al., 1974) Two early studies of burnout, Schwartz and Will (1961) and Stotland and Kobler (1965), found that staff burnout occurred in mental hospital wards because organizational changes were associated with patient neglect; patient behavior regressed and patient suicide attempt rates increased. More recently, Sarata and Repucci (1975), in studying the functioning of a community-based prerelease program for adult offenders, found that organizational events that contributed to increased job stress among staff were associated with increased client aggressiveness and a general deterioration in measures of the program's effectiveness.

Stress and burnout also contribute to increased rates of staff turnover which are both disruptive and costly to the implementation of human service programs. Kamis (1980) emphasizes that staff burnout involves both direct and indirect costs to workers, the human service industry, and society.

Approaches to Reducing Burnout

As interest in the phenomena of job burnout among human service workers has grown, workshops in stress management and methods for dealing with burnout have become commonplace. The principles and methods underlying these workshops differ considerably, however, as do assessments of their long-term usefulness.

Observers seeking to analyze the root causes of the phenomonon suggest that burnout stems from (1) internal or individual factors, which include worker motivation, intrinsic psychological traits, helping skills, knowledge of client population, ability to cope with stress, realism of expectations, professional role congruence, personal life (Maslach 1977; Pines & Masiach 1978; Larson et al., 1978; Emener 1979), and/or (2) external or organizational factors including caseload size, client population, work relationships with staff, supervisory relationships, centralization of authority, lack of index of success, salary. (Armstrong, 1977; Lamb, 1979; Daly, 1979)

Training programs currently being conducted to combat this problem may focus on different sets of suspected causes. The following training models are representative of typical burnout workshops being provided:

- An adult educational model in which the goal is to have trainees develop a realistic coping strategy that will deal with two or three of the most critical stresses in their personal or work environment. Trainees anonymously fill out evaluations of their organization which are presented to management after the workshop with the goal of generating organizational change.
- Personal regimentation planning workshops in which the affected worker is directed to schedule his or her time as if ill and in need of special care and extra rest. Among the crucial elements of this 4-week regimen are improving diet, exercising, resting, reducing social interactions, and lessening work tasks.
- Training in techniques of deep relaxation, desensitization, and increased self-concept in order to improve the worker's ability to cope with the organizational problems that are present.
- Learning the methods and techniques of Rational Emotive Therapy (RET) (Ellis and Harper, 1975) and Reality therapy (Glasser, 1975) in order to better deal with existing negative

organizational stresses. For the individual trainee, the goal is to accept reality, to assume responsibility for himself and to be able to derive enjoyment and a sense of self-worth from doing a job that is worth doing well.

In addition to such training programs, a variety of other insights and recommendations for combatting the staff burnout syndrome have been proposed. Pines and Maslach (1978) suggest that an effective approach for combatting or slowing down the burnout process is that of establishing a system of retreats outside the institutional or agency setting. Maslach's (1978) findings indicate that burnout rates are lower for professionals who actively express, analyze and share their personal feelings with colleagues. Larson, Gilbertson, and Powell (1978) believe that the encouragement of individuality within staff and the opportunity for its expression is of real importance, and that management should take the lead in facilitating such development. Kahn (1978) recommends that human service workers should put a self-preserving distance between themselves and their clients without developing dehumanizing kinds of qualities and that staff members need to be taught to develop this special skill. And Freudenberger and Robbins (1979) offer the proposition that an open sharing of ideas and goals with colleagues in a training format may be an excellent antidote to the feelings of isolation to which the human service worker is prone.

Manpower Training Issues

As noted above, deinstitutionalization programs have been characterized by considerable flexibility with respect to manpower issues over the past 2 decades. They have moved from specialized to generic role definitions, supported the growth of the paraprofessional movement and established innovative staffing patterns to meet unique needs. As these developments have occurred—sometimes according to plan but more often as pragmatic responses to pressing needs—they have underscored the urgency to create a better level of conceptualization regarding the deinstitutionalization manpower field. Many basic questions are still unanswered: are workers involved in community-based programs engaged in a new discipline, with new principles and purposes, new treatment modalities and styles, new skills and competencies? Or are they synthesizing the techniques and approaches of the disciplines in which traditional practitioners were trained?

Moreover, as discussed above, staffs of human service programs are drawn from a variety of professions, and include as well, paraprofessionals who have had little or no formal training. Typically, the training provided within key disciplines does not prepare their graduates for the particular needs of deinstitutionalized clients. Often, as noted by Glasscote (1971), Dincin (1975) and Lanoil and Turner (1979), facilities must supplement whatever skills staff do bring with inservice training specifically designed for the service setting. And although some formal training opportunities (including AA, BA and/or MA degrees) with a specific focus on psychosocial rehabilitation are slowly being developed, the question remains whether such training should be regarded as a subspecialty of rehabilitation social work or some other established profession, or be viewed as a field in its own right. Another option may be to develop training programs for practitioners at academic levels below those normally considered entry level. Specifically, training programs would focus upon working with the deinstitutionalized for persons with baccalaureate level social work degrees or with master's level clinical psychology degrees.

At present, then, the state of the art regarding educational and training programs for human service workers is largely unsettled. Caplan (1974), arguing for a more coherent approach to ordering the priorities, training needs, and available resources associated with manpower policies for those serving the deinstitutionalized, writes:

> We must utilize the resources of all caregivers in the community .... This means that we must find ways of harnessing the efforts of all potentially relevant professionals and agencies to serve the needs of

> particular individuals and families.... Our aim should rarely be the addition of new professionals and institutions because of our shortage of money and manpower, but the reorganization of institutional policies and practices and the concomitant reeducation of staffs to take on new roles. The crucial challenge will be to alter the boundaries of agency and professional domains so that their efforts can be integrated in new ways to satisfy the needs of individuals and groups.

The above statement makes clear that a wide range of interrelated concerns must be addressed if the goal of developing more responsive manpower and training directions is to be achieved. These issues, discussed below, comprise an ambitious agenda for the decade ahead and include: (1) worker selection and performance criteria; (2) continuing education; (3) academic training; (4) short-term training; and (5) competency-based training.

Worker Selection and Performance Criteria

A tension that has troubled the human service field grows out of the fact that employment selection and evaluation approaches have largely been based on professional credentialing. Such methods often have been idiosyncratic and unreliable—and occassionally discriminatory. The guidelines for implementing the Equal Employment Opportunity provisions of the Civil Rights Act of 1964 were developed, in large measure to safeguard the employment status of minorities. To help minimize the use of employee selection methods which do not reliably indicate future job performance, criteria for selection of paraprofessionals and other personnel have been formulated. (Hall, 1979) Human service agencies are encouraged to: establish measurable goals and objectives; examine the work responsibilities of those already providing service; specify measurable job performance criteria; and evaluate and identify characteristics of workers which would predict effective performance.

Selection of workers must follow a systematic process which matches a suitably qualified worker to a specific job. Predictors other than achievement tests or educational levels may need to be utilized. An approach to the consideration of appropriate selection techniques was proposed by Hall (1979) as part of her research on behalf of the Paraprofessional Manpower Development Branch of NIMH. The focus of her study was to assess the validity of instruments used in selecting paraprofessionals for direct service positions. She found that "(effective job performance) is a cognitive development process because it is through a system of ordering that one learns to adapt to stimulus, objects or events and to control one's own environment." Workers should be expected to understand a client's perception of a problem and integrate that information with physical and social behavioral data in such a way as to formulate alternative and multiple solutions. Predicting a worker's abilities in this respect may be facilitated through the use of the Paragraph Completion Test (PCT), a semiprojective psychological test designed to measure capacity to deal with conceptual thinking (Harvey, et al., 1961), along a continuum of concrete to abstract. An individual's position on that continuum influences how information gets processed, and can be utilized to project an applicant's level of conceptual complexity as well as aspects of his relationships with clients.

Related to the problem of prediction is the fact that few human service systems have statements of measurable goals which can be used to develop job descriptions and measure job performance. For both paraprofessional and professional staff members, the central question is: how effective are the services provided to the client, and how shall the effectiveness be determined? Effectiveness in this context refers to the worker's degree of success in restoring self-sufficiency and/or improved functioning to the clients with whom he or she works. Several criteria have been traditionally employed to assess counselor effectiveness: the number of successful case closures; the adjustment level of the client as rated by objective observers; the client's subjective feelings with regard to his social and vocational functioning; the family's rating of the client's level of adjustment; the client's vocational status as viewed by employer and/or counselor, etc. However, there remains a need for the development of additional objective measures of worker skills, knowledge, and job performance as related to client outcomes, particularly measures that can specify *how* a worker does a job rather than *what* is being done. Job skills tests have been suggested as one modality by which a worker's level of effectiveness may be assessed.

Continuing Education

Continuing education can be defined as "a systematic learning experience designed to improve, modify or update one's knowledge, skills or values in areas of professional or occupational practice." (SREB, 1977). It applies to formally accredited programs sponsored by colleges or universities, as well as to informal programs sponsored by operating agencies and professional organizations. Because many professional societies and licensure boards are requiring evidence of continuing education for continued membership (or for relicensure), it will be increasingly important for both formal and informal continuing education (CE) programs to be prepared to offer a credentialing certificate for participants. There are currently two major systems of formal accreditation for continuing education in mental health: Category 1 credits of the AMA, designed for physicians; and Continuing Education unit credits for other professionals.

There has been an increasing number of human service workers involved in continuing education programs, for both professional and personal reasons, and many of these workers are involved—or will soon be involved—in deinstitutionalization programs. For them, one of the problems has been that most CE in the mental health field focuses on psychiatric techniques and diagnostic categories despite the concerns of large numbers of students with the everyday aspects of psychosocial functioning. Unfortunately, there have been to date very few formal or informal continuing education programs with a clear emphasis upon the delivery of services to deinstitutionalized persons, either with regard to direct care skills or broader program planning techniques. This leaves not only psychiatrists but also the entire spectrum of human service workers without an opportunity to develop expertise in a field of growing importance while earning required CE credits. If the human services field concerned with the deinstitutionalized is to make substantial progress toward effective training, programs of continuing education will have to be preceded by a systematic analysis redefining trainees' vocational needs.

Academic Training

The primary purpose of continuing education programs is of course, to bring current practitioners up-to-date. In most cases CE programs offer those in the field an opportunity to master material that has already become part of the basic education provided to new graduates of academic training programs, particularly those at the graduate level. This, however, is not the case in the deinstitutionalization field, for there has been surprisingly little progress made in the colleges and universities toward revising course curricula and academic requirements to reflect the community program needs of the deinstitutionalized. No new discipline has evolved in the academic setting to address these issues.

At the paraprofessional level, however, the situation is somewhat different, in part because the training of paraprofessionals is a considerably newer academic activity, and thus more open to innovation. For instance, a training module developed at the University of South Florida for training paraprofessional mental health workers at public mental hospitals (distributed nationally through ERIC, the Educational Resources Information Center) emphasizes rehabilitation-oriented skills. The module combines six new competency-based courses and four existing community college courses. Together they provide 32 semester hour credits, either leading to a certificate in human service or providing credits that can contribute to an associate degree. The six new modules specially developed in this unique academic training program can also be used for noncredit or inservice programs. They are: (1) Human Relations Skills; (2) Interviewing and Influencing Skills; (3) Psychosocial Assessment; (4) Techniques of Intervention; (5) Integrative Seminar in Human Service; and (6) Health Assessment. (Slater, Gordon, and Redcay, 1979)

Short-Term Training Program

Short-term training programs targeted toward specific levels of service delivery staff in community settings have been increasing dramatically in recent years. At the State level, deinstitutionalization planners and human service administrators have increasingly recognized the unavailability of trained staff to provide new services. In those States where a rapid development of residential or vocational rehabilitation programs has been undertaken, for instance, there has frequently been an effort to provide short-term training that could improve the performance of otherwise inexperienced staff. Individual agencies have also been forced to respond to the shifting demographics of their clients and have begun to look for short-term training programs to upgrade staff skills. Some of the programs are quite specific (Management of the Aggressive Client in the Community Residence), while others are more general (Principles of Psychosocial Rehabilitation). They share, however, a contemporary, programmatic approach to problem solving. These programs, usually 3 to 5 days in duration, aim at upgrading staff competencies in a variety of human services. For instance, Horizon House Institute, a private nonprofit human service organization in Pennsylvania, provides a number of short-term training programs supported by Federal, State, and individual agency funds. They are:

- Rehabilitation in the community residence, is a 4-day training course for staff of community-based residential programs for the psychiatrically disabled, supported by Pennsylvania's Office of Mental Health and designed to address training in the needs and characteristics of the Community Rehabilitation Residence client population, rehabilitation approaches, helping skills and crisis intervention, activities of daily living skills, household management, goal planning, and program policies and legal issues.
- Community acceptance of the mentally ill, a program supported by a grant from the Center for Mental Health Services Manpower Research and Development of the National Institute of Mental Health, draws together public educators in the mental health field for a thorough examination of issues and alternatives for promoting community acceptance of the deinstitutionalized. The training focuses on siting residential facilities, developing statewide public education strategies, revising zoning regulations, approaching the media, and improving employer acceptance.
- The home care training course is targeted toward paraprofessional providers of housing for chronically ill mental patients and the elderly. Funded by the National Institute of Mental Health, the course curriculum reflects the proprietors' needs. Among the topics are Federal, State, and city laws and regulations; license and insurance; nutrition and health care; psychotropic medication; understanding mental illness; and activities for residents.

Each of these programs is designed for a specific set of human service workers, and the training activities focus almost exclusively upon the theories and practices relevant to their ongoing work. Similar training programs are offered all across the country: some move from agency to agency, providing the training inhouse; others move from city to city to enlarge the number and variety of trainees; and still others offer regular institutes within their own facilities. Rapid staff turnover combined with the equally rapid pace of program development in many States suggest the need for an ongoing commitment to short-term training programs, and thus the need for a new and/or expanded funding base to support this activity.

Competency-Based Learning

The term "competence" refers to whatever skills or qualities it takes to accomplish a task adequately, as measured against some specified standard of performance. Academic degrees by themselves often do not adequately predict competencies, and should not be the basis of hiring or assessing human service worker skills. As we have seen, academic degrees have often left graduates with few practical skills with regard to deinstitutionalized populations. We need more facts about what makes a worker competent, and more guidelines for measuring these competencies.

Nevertheless, there have been a number of recent efforts to develop an effective competency-based curriculum on the basis of what Robert Gagne (cited in Butler, 1977) calls a hierarchy of learned performance. This represents a continuum of competencies to be learned, ranging from simple responses to complex problem solving. Gagne's scheme delineates several levels. At the most demanding and generalizable level are *global competencies.* Examples of such competencies for human service workers would be the ability to assist clients to clarify their values and the motivations for their actions. *Enabling competencies,* derived from the global, describe the knowledge, skills, and attitudes that are related to more specific human service worker performance. This is often the level at which students are evaluated. Enabling competencies include the ability to utilize a recognized therapeutic approach to effect individual change or a talent for analyzing the development stages a task group will need to experience in attaining its goal. At the most basic level are *learning competencies,* describing the human service workers' grasp of the sequential learning steps included in acquiring special knowledge and skills.

Pottinger (1977) affirms that competency training should involve more than the most basic instrumental skills. He suggests that a trainee's motivation, interpersonal skills and cognitive abilities are each important dimensions of performance that are highly related to competence but rarely considered in licensing examinations. He states:

> The amount of knowledge of a content area is generally unrelated to superior performance in an occupation. More important is that an individual be willing and able to learn to do new things . . . (and that one have) conceptual skills that enable one to bring order to the informational chaos that characterizes one's everyday environment . . . How is the knowledge *used* to come to grips with the practical problems of the work situation? (Pottinger, 1977 SREB)

There is an accelerating trend among human service workers to secure some form of licensure; in essence, the attempt is to demonstrate competence. Although the purpose of licensure under most State laws is to protect the public by identifying qualified practitioners, Chapman (cited in Gottfredson and Richards, 1979) points out that it may also function to "stake out a profession's territory," thereby potentially excluding competing practitioners. As a result, those whose career identities are tied to a particular target population (such as correction workers and alcoholism counselors) have frequently been excluded from work with other special populations, theoretically on the grounds that no "competence" has been shown in the new field. Critics argue that the methods of testing are often so restrictive as to be unable to measure the most critical aspects of competence as they might apply across several disciplines.

Thus, a developing trend has focused upon certification based on competence in the functions required in working with a client population. NIMH is currently funding three projects with the Southern Regional Education Board (SREB), whose aim is to further explore and develop this alternative. The Worker Certification Project, the Program Approval Project and the Paraprofessional Career Enhancement Project are charged with developing competency-based assessment methods and training materials in group therapy and individual therapy. (SARC, 1979) For such an approach to be viable in the long run, however, it must be tied to job descriptions and personnel systems which must either be centered on a functional/competency basis (SREB, 1977), or at least be sensitive to such issues.

A Final Note

A systematic plan for the training and integration of the various professionals and paraprofessionals currently involved in the delivery system of human services must be developed if deinstitutionalization programs are to offer quality care. In order to accomplish this, the following recommendations are suggested:

- A generic orientation for the human service worker is needed. We must identify com-

monalities in functioning and levels of generic competence within the overall human services field so that these can be addressed in academic, continuing education and inservice training programs for those who will offer services to the deinstitutionalized.

- Priority should be given to upgrading and retraining current human service workers whose job responsibilities have shifted or expanded to include services to the deinstitutionalized.
- Collaboration between academicians and practitioners should be fostered in projects which attempt innovative training programs that can bring the skills of current community-based program staff to professional training.
- Continuing education for professionals—around such issues as community care and psychosocial rehabilitation—is vitally needed.
- Human services must move with all other fields toward outcome standards. The competence of human service workers should be assessed on the amount and nature of impact on clients and communities.
- Most important, a flexible, easily employed credentialing system for human service workers is needed. Certification should be focused on general competencies, qualifying workers for a wide range of jobs in the human services field.

Because deinstitutionalization programs have required new kinds of skills, new categories of workers, and the infusion of large numbers of both professional and paraprofessionals to meet new demands, there remains considerable confusion in the field with regard to job definitions and job requirements. In a sense, this confusion also represents an opportunity to move toward a cross-disciplinary perspective on the needs of clients in the community. To take advantage of this opportunity, the field will need to experience a revitalization of training programs in both academic and inservice settings. A few innovative training programs are underway and provide initial direction for the field, but a great deal more will need to follow.

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VII. Deinstitutionalization at Risk: Public Response to Community Care

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Introduction

Deinstitutionalization is not a popular movement. For the most part, it has been professional commitment rather than enlightened public opinion that has propelled the shift from institutional care to community alternatives. As the deinstitutionalization of human services systems has proceeded over the past 2 decades, increasingly vocal segments of our society have raised serious questions about the practical impact of these dramatic changes upon both the deinstitutionalized and the communities to which they return. Today, deinstitutionalization is at risk, a bold policy that may flounder in its third decade for want of public support.

Indeed, even professionals have often been sharply divided over the value of deinstitutionalization, particularly in the absence of a comprehensive network of alternative community services. (Reich and Siegal, 1973) These concerns have been echoed by relatives, advocacy organizations, and the deinstitutionalized themselves. But even stronger resistance has come from the public at large, concerned about the escalating costs of community care and the perceived threat to the quality of community life that is implied by the emptying of institutions.

Public dissatisfaction with deinstitutionalization policies has its roots in the failure of community care's advocates to communicate their concerns to the broader public. In the period after World War II, one institutional system after another was reviewed and found wanting. State hospitals for the mentally ill, State schools for the retarded, treatment programs for drug and alcohol abusers, juvenile detention facilities, prisons for adult offenders, nursing homes for the elderly, and institutions for the physically disabled were all subjected to the same basic criticism: institutional care was often a costly and counter-therapeutic modality for persons who, with professional support and community acceptance, could function more independently in noninstitutional settings. Neither professional disillusionment nor consumer dissatisfaction with institutional care, however, was ever widely shared with the public.

Occasional glimpses of the despair of institutional life have, of course, made their way into the public record. The exposure of woefully inadequate conditions at State mental hospitals in the immediate postwar years (Deutsch, 1973), a television documentary of physical neglect at the Willowbrook New York State facility for the mentally retarded (CBS, 1974), and recent Congressional hearings on abuses in the nursing home industry (The Role of Nursing Homes, 1976), are examples of highly publicized examinations of the nation's institutional care systems. Public shock and outrage usually followed such disclosures. But there is a difference

between a momentarily aroused public and widespread, ongoing citizen support for the public investment and private sacrifice necessary to implement effective deinstitutionalization programs.

Thus, while many professionals, consumers, and advocacy organizations have successfully promoted deinstitutionalization in the wake of such disclosures, public support has been vacillating and short-lived. In reality, most deinstitutionalization efforts have gone forward under administrative fiat or court mandates, rather than as an expression of public or even legislative will. For instance, in the mental health arena, legal imperatives (O'Connor vs. Donaldson, 1975) have forced many States to develop plans to phase down the use of institutional facilities; Federal policies and court orders have prodded State administrators to move more quickly toward "normalization" of care for the retarded (Wolfensberger, 1972); affirmative action programs for the physically disabled have forced changes that have had an impact on many aspects of public life (Koestler, 1978); and nursing home scandals have moved State and municipal authorities to improve community services and tighten licensing standards. But few of these changes have been widely supported by the public, which has not accepted the proposition that community programs provide an unobtrusive and inexpensive solution to institutional inadequacies. While public attitudes toward institutionalized populations may have improved marginally over the past few years, this improvement has not lent significant support to the development of community services.

The basic professional critique of institutional care is not that abuses occur within it, but that institutions by their very nature serve as barriers to successful community reintegration. The underlying principle of community care has been that placement in the community can inherently make a contribution to positive adjustment. Neither the disadvantages of institutional care nor the potential benefits of community treatment has been fully understood or accepted by the public. There has been little shift in the public's perception that the basic need is to find a safe custodial setting for populations in need of care. Thus, for instance, residential facilities for the mentally ill and mentally retarded still face fierce resistance from their prospective neighbors (Piasecki, 1975); treatment facilities for substance abusers and offenders may be forced into marginal and/or commercial neighborhoods to avoid opposition (Scott and Scott, 1980); and public resentment over the costs of accessibility for the physically handicapped continues to rise. (CBS, 1979)

Despite all this, deinstitutionalization planning has been undertaken as though community support were assured, when in fact public resistance often has impeded deinstitutionalization's progress. The danger is that deinstitutionalization programs may become little more than an adjunct to institutional systems of care. The criticisms of hospital-based services—that they are therapeutically ineffective, financially costly, and constitutionally questionable—may be more readily resolved, from the public's perspective, by improving the quality of institutional care. This appears a reasonable option to those convinced that community-based services pose a clear threat to the safety, quality, and stability of community life. Clearly, a much greater effort to win public support must be undertaken by those planning deinstitutionalization policies for the future.

The Impact of Public Resistance

Public resistance at best slows and at worst permanently stalls deinstitutionalization advances. There is a tendency among human services professionals both to minimize public antipathies toward the people they serve and to ignore the impact of public resistance. And, although there is evidence from public attitude surveys (Taylor, et al., 1979) to suggest that substantial numbers of people express essentially benevolent responses to the notion of community care, it is important to recognize that a strident minority can often frighten an otherwise accepting community. Clearly, those who give the "right" or socially acceptable

answer to such surveys retain the option of acting in a quite different fashion when the chips are down. When this happens, the impact may be felt at individual, programmatic, and planning levels.

At the individual level, the unavailability of an adequate number of supportive community settings has meant either continued institutional care for those who no longer need it or abandonment to communities where few or no support services can be found. (Baron and Piasecki, 1981) Residential programs delayed or scrapped because of community opposition leave few alternatives open to the institutional resident ready to test the challenges of an independent community life. Further, because employer attitudes often mirror broader social belief systems, the deinstitutionalized experience far higher rates of unemployment than virtually any other group. (Anthony, et al., 1978) Social opportunities are equally limited: for those without a preexisting network of family and friends life in the community can be little more than bleak solitude. (Community Careers, 1975) *De facto* segregation of the deinstitutionalized, without decent housing, job opportunities, or social contacts, takes a cruel toll, and yet every major urban center in the country has its own ghetto where the deinstitutionalized are gathered to find the acceptance and support unavailable elsewhere in the city.

At the programmatic level, public opposition has led to delays in facility start-up that are often devastating. Residential facilities have had the most difficulty, often suffering through neighborhood protests, zoning board hearings, court challenges, appeals, and more before they can open their doors. Data suggest that such delays lead to substantial financial costs, including inflationary rises in construction or renovation expenses, salary expenditures for staff who have been hired but cannot work in their facility, and the monies that go into promotional materials. (Piasecki, 1975). These costs are often unrecoverable. Equally important are the changes in programmatic direction dictated by adverse community response: a potential site in a desirable neighborhood may be relinquished in favor of a building in a marginal (but more attainable) community, where a number of other similar facilities may already exist. (Stickney, 1976)

Long-range planning efforts face similar obstacles. In New York, State level plans to phase down institutional services and develop community support networks for the mentally ill were abandoned because of the public furor such plans created. (Medical World News, 1974) In California, a series of sensationalized murders by expatients led to public pressure on the State legislature to halt the planned closure of additional State hospitals. In Massachusetts, the precipitous dismantling of institutions for youthful offenders resulted in widespread public outcries (Santiestevan, 1975) that led to resurrection of those institutions only a few years later. Even in court-mandated deinstitutionalization programs for the retarded, such as those underway at the Willowbrook, New York, and Pennhurst, Pennsylvania, institutions, community protests have forced extended legal battles as well as a more cautious approach to the establishment of community facilities. At the same time, community protests have also dampened legislative enthusiasm for deinstitutionalization. More than any other segment of society, legislators were sold deinstitutionalization on the basis that it would prove a less expensive treatment alternative. This has not yet proven to be the case. As a consequence, stable funding patterns for community services generally do not exist. Without more lasting public support, they will not exist, for legislators cannot forever appropriate funds to unpopular programs.

Perceptions of the Deinstitutionalized

Deinstitutionalization planners can no longer afford to ignore the need to generate broad-scale public support for deinstitutionalization programs and facilities. In this regard, it is useful to note that although two very different kinds of "publics" must be addressed, their

perceptions of the deinstitutionalized and their concerns about deinstitutionalization are more similar than dissimilar. The first "public" is composed of community members whose fears and concerns reflect both aged myths and currently disquieting realities. The second "public" is comprised of special constituencies such as professionals, unions, legal advocates, and Federal or State legislators, whose policy preferences and political influences will play a decisive role in establishing programmatic directions for the remainder of the decade. Despite the greater opportunity for this second public to be far better informed about the issues related to deinstitutionalization, their attitudes are surprisingly similar to those held by the general public. This is really not so remarkable when one considers the highly interactive nature of the two categories, for they are often dependent upon one another for information, leadership, political power, and support.

Those who plan deinstitutionalization services often tend to cherish a different set of perceptions entirely. Planners are so convinced of the therapeutic and moral justifications for deinstitutionalization policies that they often inadvertently minimize community concerns. Certainly some of a legislator's or neighbor's anxiety about community services is based upon myth and misinformation, but it is important to recognize that the concerns articulated by these two publics are both real and compelling. In general, public concerns cluster around three central issues: (1) the violent nature of the deinstitutionalized population (threat); (2) the inadequacy of community-based programs to serve them (implementation); and (3) the broader social forces that are already acting to destabilize community life (control).

Threat: "These people are dangerous"

Often the overriding issue in public resistance is the degree to which the presence of deinstitutionalized persons creates fears about violent behavior in the community. The mentally ill, the retarded, the exoffender, the substance abusers are all seen as threatening, with each implying an increase in public nuisances, theft, physical attacks, and sexual molestation. (Rabkin, 1974) The tendency on the part of deinstitutionalization advocates to deny that such problems exist, or the temptation to guarantee either that discharge reviews can always screen out the dangerous client or that facility supervision can always control client behavior, distorts the reality. Further, in the face of a continued media focus on those few incidents that do inevitably occur (Koenig, 1978), such denials and assertions are unlikely to be accepted by community members. Although there is evidence to suggest that the incidence of violent behavior among the deinstitutionalized is in fact quite small (Rabkin, 1978), communities often want absolute guarantees about public safety. The problem is intensified by the tendency of advocates for each of the populations discussed here to scapegoat one another on just this issue: the retarded are not like the unpredictable mentally ill; the mentally ill are not drug fiends; drug abusers are not proven criminals; the decarcerated are not the morally obtuse mentally retarded; and so on, around this vicious cycle of recrimination.

Implementation: "It's a sin the way they have to live"

Communities are also concerned about the ability of local human service systems to care adequately for the deinstitutionalized. While it is true that many thousands of previously institutionalized persons have returned to productive, satisfying lives in the community, thousands of others have not been so fortunate. Abandoned to welfare hotels, exploitative boarding homes, single room occupancy facilities, or simply the streets (Philadelphia Magazine, 1980) they constitute a new and unwelcome substrata in the society. The problem may be that the successfully deinstitutionalized are all but invisible— reabsorbed into family settings, familiar jobs, and social networks—while the others, victims of 20 years of haphazard deinstitutionalization policies, are altogether too noticeable. Community concerns in this regard may be either benevolent or self-serving, or perhaps both. On the one hand, there is a genuine empathy for those unable to find the help they need to succeed in the community or who fall between the cracks into a substandard existence. The lament that "it's a sin the way

they have to live," is heartfelt. On the other hand, planners should recognize that the very communities asked most often to bear the burden of accepting deinstitutionalized populations are themselves—or may soon become—communities in distress, unpleasant places to live, and beset by some of society's most intractable social and economic problems.

Control: "Who's in charge here, anyway"

There is a widespread assumption that the presence of the deinstitutionalized lowers the quality of life in the community and, as a consequence, lowers property values as well. The reality is that some communities do become oversaturated with deinstitutionalized individuals and programs, and this does have a negative impact upon the tone of the neighborhood and the value of the housing. The reality is also that where oversaturation does not occur, such phenomena are not found. (Wolpert, 1978) Nonetheless, communities are wary of the introduction of new and unpredictable elements into the neighborhood. Communities want a reasonable measure of control over who will be moving in, and in this regard the problems faced by deinstitutionalized persons parallel those faced by racial minorities or the economically disadvantaged. Community concerns are further heightened by the nation's growing uneasiness about personal safety, particularly in urban residential areas. The generosity of spirit and neighborly trust that may have characterized communities a generation ago has largely receded. In their place are individuals struggling to safeguard their security and standard of living.

Thus, we can expect to see public receptiveness mediated by public realities. That most Americans believe that the mentally ill are dangerous is of course unfortunate, but it becomes a more potent factor in a society already tense about the escalating degree of violence in our midst. The belief that property values decrease in a community which is host to one or more halfway houses can become a more compelling argument when a family's primary financial security is its home. The challenge, of course, is to convince the public that the benefits associated with deinstitutionalization still outweigh the risks.

Programmatic Change vs. Public Education

Service professionals, union leaders and legislators have much the same fears as the community member about the threat posed by the deinstitutionalized, much the same concerns about the inadequacy of community treatment, and much the same pressures to balance the budget. To move deinstitutionalization forward, these issues must be addressed. Two complementary agendas need to be established. The first focuses upon programmatic changes that lead to both qualitative and quantitative improvements in deinstitutionalization implementation. The second emphasizes the need for ongoing, responsive public education strategies.

Programmatic changes in the way deinstitutionalization is implemented can have a positive impact on public acceptance. In the field of mental health, for instance, community residential care providers have reported much less public protest directed toward small apartment programs than larger group homes. (Goldmeier et al., 1978) Programs for the mentally retarded are more readily absorbed when their clientele is higher functioning and lower risk than the community anticipates. Sophisticated communities are now likely to ask programs for drug and alcohol abusers about the stability of their funding base, and are more prepared to accept the program if it is clear that the property is to be well maintained over the long-term. Civic associations show concern about staff/client ratios, a particularly important issue, for instance, in community programs for juvenile and adult offenders. Assurances on each of these issues—size and nature of the program, functioning level of the residents, stability of the funding base, and supervision of the clientele—can help improve public receptivity.

But there are also problems associated with relying exclusively upon such programmatic features to win public support. Small, rehabilitation-oriented programs for higher functioning clients are critically important, but they do not meet the needs of the large numbers of seriously disabled persons who require both long-term professional support and community acceptance to function in society. The growing inclination to view community facilities for the more seriously disabled (and the more socially unacceptable) as only mini-institutions not worth the expense and effort required to keep them running, does a disservice to their clientele, who often benefit substantially from community care despite the chronic nature of their disability and their inability to achieve full, functional independence. (Lamb, 1981)

If programmatic changes provide only a partial response to negative community attitudes, public educational efforts must then receive a higher planning priority than they have heretofore received. A number of public education tasks must be addressed. There is a need to grapple directly with the fearful, negative attitudes toward these populations that persists across every community; we must emphasize the fact that deinstitutionalization initiatives have succeeded in the past and can succeed in the future; and communities must be convinced that deinstitutionalization—if properly implemented for an appropriate clientele—is the correct course to follow. These issues have rarely been addressed in the past, for several reasons. The easy assumptions that communities would welcome (or at least tolerate) new and different people, that funding would shift from institutional to community care, and that our liberal social values were likely to persist have now proven wrong; for a decade, however, they made broad-scale public education campaigns in support of these policies seem unnecessary. Those who sensed the rising level of public opposition tended to avoid confronting it, for the anger and anxiety of a frightened community is not pleasant to face, and the answers to their accusations are not readily available. Although more is being done to confront these issues today, planned programs to counteract community resistance remain a low priority.

Further, there are serious questions about how to design effective public education programs in this arena. Two major, contrasting strategies have both been popular. Traditional campaigns— particularly in the social services field—view the securing of public support as requiring public informational efforts. These lead to public attitude changes that in turn create supportive public behaviors. For instance, providing the public with information about the work potential of the physically disabled, which is a potential frequently wasted because of inaccessible worksites, can improve public attitudes about the productivity of the physically disabled at work and lead to public support for the costs of providing access to job opportunities. Similarly, an educational campaign emphasizing that the mentally ill are no more dangerous as a group than the general public should reduce the fear of expatients and in turn move municipalities toward less restrictive zoning ordinances. Other educational programs that spotlight the needs of juveniles or the rights of the retarded take the same approach to improving public receptivity: they begin with providing the public with information that they believe will lead to both attitudinal and behavioral change. Although there is little evidence available to demonstrate conclusively that this process (information gain leading to attitude change leading to behavioral change) really works well enough to justify the substantial time and costs entailed, it is the way most human service public educators approach their role as agents of change. The process is essentially a collaborative one in which public educators work with individuals or communities to develop a mutual understanding of problem areas and to agree on reasonable solutions.

The major alternative strategy is to mandate change, forcing individuals to alter their attitudes and in turn making it necessary for them to gain new information to justify their new beliefs. (Fishbein and Ajzen, 1972) For example, a court-ordered change in zoning legislation (from restrictive to nonexclusionary zoning statutes) forces citizens into contact with the disabled, often resulting in unexpected favorable attitudes toward the new neighbors, and leading to a need for more information that can help resolve the cognitive dissonance thus created. Employers forced by affirmative action mandates to hire the handicapped find them to be competent employees, and seek the data they need to prove it both to themselves and to

others. Organized pressure to alter stereotyped images of the elderly in the media or the availability of tax incentives to encourage employers to hire the decarcerated operate from the same assumption: the behavioral change provides the motivation necessary to change otherwise intractable attitudes. (Bem, 1970) This structural approach is based on the premise that behavioral change leads to attitude change which in turn leads to information gain.

The tension between collaborative and structural approaches to produce change cannot be readily resolved. Neither one can yet demonstrate greater short-run effectiveness, if only because virtually no research has been done in this area. Collaborative strategists argue that there is no point in placing the deinstitutionalized in hostile communities, where the opportunities for social integration are all but nonexistent. (McDowell, 1978) Structural strategists point out that the time and money spent in convincing the community is better expended on establishing programs to which communities can and will become accustomed. (Rothman, 1980) Both claim superior long-run efficacy with collaborative strategists contending that lasting change in public receptivity can only be the product of personal commitment, and structural strategists arguing that today's legal mandates become tomorrow's social mores. And neither side is willing to grant the other moral superiority, with one side committed to democratic community control and the other side committed to the rights of the deinstitutionalized.

Planning for Community Support: The Public At Large

Planners of deinstitutionalization/public education programs have a range of options to pursue. In the pages that follow we examine a number of public education tasks that can be expected to arise: siting residential facilities, promoting open zoning legislation, encouraging employer acceptance, altering harmful media images, and developing broad-scale public education campaigns. Within each area, planners and public educators have both collaborative and structural options from which to choose.

Siting Community Residences

The choices between collaborative and structural approaches to the community can be seen most clearly with regard to the siting of residential facilities. Every human service system planning for deinstitutionalization has sought to establish halfway houses, group homes, or apartment programs, and each has faced serious community opposition. System planners are now aware that they must insure that adequate numbers of residential care homes are available before large-scale deinstitutionalization initiatives are undertaken. They are less aware that they will encounter frequent delays in facility startup unless they plan in advance how to respond to community opposition.

Many practitioners have taken a high profile, or collaborative approach, which involves informing a community beforehand, providing opportunities for information sharing and debate, and encouraging resident contact with prospective neighbors. This has included door-to-door visits in a prospective neighborhood, distribution of informative literature in the immediate neighborhood, community-wide meetings to clarify the goals of the home and answer neighbors' questions, soliciting favorable coverage in local media, arranging contact with local opinion leaders or politicians, and hosting an open house soon after the facility is opened. The rule of thumb in such efforts is to assess carefully the community beforehand, and to select those communication channels that work most effectively in that particular neighborhood. (Warren, 1975) Others have taken a low profile or structural stance, quietly acquiring a site, making unobtrusive improvements, and slowly introducing staff and clients. Low-profile advocates are careful to try to match the characteristics of staff and clients to

those of their neighbors, to use realtors to manage most of the technical work of acquiring a site, and to make as few changes in either the exterior or interior of the home as possible. Although no special effort is made before or after siting to inform the community, inquiries from neighbors are responded to accurately and quickly, but with little fanfare.

Successes and failures are reported on both sides. High-profile efforts may serve only to heighten community awareness and to lead to stronger community opposition. Low-profile tactics sometimes result in lasting community resentments. Until further research provides greater clarity as to which approach works best in which communities, practitioners are forced to decide between the two on the basis of their own preferences.

It is clear, however, that in either high-profile or low-profile efforts there are tactical approaches that can smooth the siting process. Among them are the following:

- Provide honest, accurate information. It is important that honest and accurate information be provided to the community, whether that information comes prior to siting (high profile) or after the neighbors have become aware of what's next door (low profile). Most important in this regard is the ability to deal directly with community fears about the dangerousness of the home's residents, about the quality of care residents will receive, and about the degree of control neighbors will have in the operation of the facility. It is easy to become either overly defensive or too reassuring, neither of which serves to calm a worried community. Know the facts, which in most cases do warrant optimism (Steadman, 1980), and find a reasonable way to present them that does not insult the community by trivializing its concerns. Rehearsal helps!
- Establish responsible release and reasonable supervision policies. Communities often harbor the suspicion that institutional residents are released en masse, with little or no effort made to distinguish between those who can and cannot handle community life. Establish discharge procedures that safeguard the client's individual civil liberties while reassuring communities. Then, develop comparable policies with regard to client supervision in the community residence. Both policies can make a community aware of the importance attached by planners and providers to their concerns.
- Seek long-term funding patterns. Communities are wary of a new program that has an infinite funding base. Neighbors are understandably worried that the newly renovated halfway house will not be adequately maintained or sufficiently staffed 5 years from now, or that the small group home for older, retarded women they have agreed to accept today will be forced later to become a set of apartments for mentally ill young men as funding patterns shift.
- Work closely with other local providers. The likelihood that a facility's residents will be idle—gathering on porches, lounging around the corner store, or occupying the coffee shop—is a frequent source of concern. So, too, is the possibility that residents will be unable to get the professional help they need when they need it. Both issues can be resolved by insisting that each residential facility make consistent efforts to work closely with other service providers (in the areas of health, income support, recreation, psychiatric emergency care, vocational rehabilitation, etc.) to assure continuing care for their clients.
- Utilize small facilities, and disperse them. There is growing evidence that communities object to large facilities more strenuously than to small ones. (Rutman, 1980) For this reason, among others, many planners have moved away from the traditional halfway house and toward small group homes (often no more than five or six residents), scattered or clustered apartments, or individual placements in foster homes. In so doing, planners have also recognized the need to disperse such facilities across a variety of communities, avoiding whenever possible the oversaturation of inner-city neighborhoods. (Mental Disability Law Reporter, 1977)
- Establish mechanisms for local control. Sooner or later host communities express interest in assuming some measure of control over the facility. This can be done through appointments to a Board of Directors or an Advisory Committee or, in the instance of a well-

organized community, by assisting civic associations to undertake direct operational responsibility for the facility. It is important to know beforehand how much authority you wish the community to have: neighbors may attempt to screen out men, or blacks, or more disabled clients, or to insist upon curfews, or other restrictions that staff feel are inappropriate. On the other hand, active community participation can provide resources and opportunities for social integration that may be otherwise unavailable. (Stickney, 1976)

Each of these tactics should be examined by planners at both State and local levels before siting efforts are initiated. Informational materials should be developed, institutional release policies and community supervision practices clarified, long-term funding patterns established, and so on. But even if such actions are utilized, frightened communities may still reject the community residence, and make it stick. Too many agencies have assumed that they could overcome community opposition by simply sponsoring a community meeting, showing a film, and answering questions. This rarely works. An angry neighbor, a concerned parent, a stubborn ward leader can raise the emotions in the room in a moment, rejecting rational discourse for subjective impact. The public meeting can only be a part of a larger effort to gain access to the community.

Open Zoning

The siting of residential facilities is often accompanied by community protests of various kinds. Picketing, letters to the editor, pressures on local legislators, the social isolation of the facility's residents, and even occasional violence are all part of a neighborhood's armamentarium of resistance. Although these are potent weapons, the most effective barrier faced by residential facilities remains exclusionary zoning legislation. Indeed, it is a cardinal rule among many practitioners to avoid zoning battles at all costs.

Exclusionary zoning legislation has its roots in the legitimate desire of communities to establish stable patterns of land use that would maintain the residential character of one community while concentrating light industry in another, gather commercial establishments in one part of town and confine heavy industry in another. Most communities, particularly those residential neighborhoods where halfway houses, group homes, and apartment programs would be most beneficial, have relatively restrictive regulations regarding the types of structures that will be tolerated. The central problem has been that until recently group homes and halfway houses (as well as nursing homes and foster homes) have been excluded from the very neighborhoods they feel are most desirable because they have not fallen within the traditional definition of a "family." Advocates for the disabled have responded in one of two ways: challenging the definition of "family" in the courts, or seeking overriding State legislation that would remove the authority of local zoning boards to exclude such facilities. (Cupaiuolo, 1977)

Over the past decade a number of court decisions, at local and State levels, have supported the position of plaintiffs who argue that 6 to 8 disabled persons living together can be construed to be a "family" and cannot constitutionally be denied the right to purchase or lease property in a residential area. Other courts have held that a State's power to override local ordinances (eminent domain) can be used to site residential facilities if a State's deinstitutionalization policies require the siting of additional homes. Recently, however, State supreme courts have taken a more cautious view, asserting that while a redefinition of family and the exercise of eminent domain may be valid, States are within their rights not to so redefine their terms and not to utilize eminent domain authority. (Brownfield vs. State, 1980) The focus has shifted, as a result, from the courts to State legislatures. Proposed State zoning laws supporting the establishment of residential facilities have forced a confrontation between deinstitutionalization advocates and the defenders of local government authority over land use. In a number of States (e.g. Massachusetts, Wisconsin, and Florida), recent State zoning legislation has opened the majority of residential communities to the admission of small group homes serving a variety of populations. Zoning legislation is in essence a struc-

tural approach, establishing through law new limitations on the rejecting behaviors of local communities.

In New York, this structural approach to forcing change has been combined with a more collaborative strategy mandating community/facility cooperation. New York's Padavan Law (Padavan, 1979) requires facilities to give prior notification to a target community of its siting intention. The law then gives the municipal government an opportunity to object to the choosen site, explain its reasons, and offer an alternative. No facility may select a site in a neighborhood already saturated with similar facilities. Disagreements between the community and the facility about the appropriateness of a specific site are settled by the Commissioner of Mental Health. Unfortunately, advocates on both sides of this particular piece of zoning legislation—structured and collaborative—are mired in court challenges at present.

Several principles of effective zoning have emerged, nonetheless, which constitute important aspects of any overall plan for deinstitutionalization. They are:

- Establish open zoning legislation early. Any planners either overlook the need for open zoning or presume that political pressures to alter exclusionary zoning laws will develop as the need for residential facilities expands. This is not so. What actually happens is that once local communities become embroiled in a specific zoning conflict they are adamant in their refusal to rewrite their zoning statutes. The business of drafting, lobbying for, passing, and implementing zoning legislation at the State level, which then becomes necessary, can be a lengthy process with high odds against success.
- Limit the size and type of facility permitted. Most current State zoning legislation opens communities to small facilities (4 to 12 residents) and continues to exclude larger residences. At the same time, they often specify the types of services that can be provided (primarily residential) and the staffing patterns and supervision required. Zoning legislation that is less specific frequently meets more vigorous opposition.
- Draft zoning regulations that cross disciplinary lines. Too often each deinstitutionalized group has sought its own legislative dispensation. The most successful in this regard have been the advocates for mentally retarded children. Single-group legislation makes it more difficult for other groups to seek similar legislation. An omnibus bill that covers a variety of disabled populations—while initially creating more difficult problems of coordination and public relations—ultimately provides a stronger constituency for both passage and effective implementation.
- Utilize the licensing powers of the State. In some States, open zoning legislation applies only to those facilities operated or licensed by State agencies. This is designed to provide communities with an additional assurance of quality programming, and also gives neighbors the feeling that there is someone to complain to who can apply a reasonably threatening sanction if a facility fails to perform adequately.
- Maximize opportunities for input. The framing of State zoning legislation provides an opportunity for planners to build in a measure of community input. New York State's zoning laws mandate prior negotiations between a planned facility and its prospective host community. Other States have insisted upon neighborhood advisory boards. In all these cases, the legislation is designed to promote a dialogue.
- Guarantee dispersal of facilities. Because the history of residential facility siting is replete with examples of oversaturation of neighborhoods, zoning legislation should contain provisions for dispersal of homes for the disabled. There are several formulas for this: up to 1 percent of an area's population may reside in such facilities; homes must be 2,000 feet apart; neighborhoods must accept an equitable proportion of institutional residents; etc. (Lauber and Bangs, 1974) The basic thrust, however, is to guarantee communities that oversaturation will not occur simply because one particular neighborhood is too poorly organized to mount effective resistance.
- Provide for community education. As with deinstitutionalization itself, revisions in zoning regulations alter widespread assumptions about the degree of control a community exer-

cises over its own development. Once passed, advocates for such changes must insure that an extensive educational campaign (for both local public officials and the general citizenry) is undertaken. Indeed, communities have demonstrated a capacity to ignore or sidestep such legislation, and have utilized complex court challenges as delaying tactics. As with any law, passage is not the end of the road. Effective implementation will once again depend on the degree and depth of public understanding and support.

Employment

Being part of a community should mean more than simply residing within it. Most people want and need to be involved in the vocational and social life of the community. Too often, deinstitutionalized persons find themselves successfully placed, but unable to establish any other meaningful ties to the community around them. For this reason, deinstitutionalization planning should place strong emphasis upon employment, which provides not only income, but also role definition, social relationships and heightened self-esteem. For the deinstitutionalized, however, employment is often hard to find. Unemployment rates among the mentally and physically disabled are high, as they are for exoffender and substance abusers. Employers' attitudes toward the deinstitutionalized are frequently negative: they are perceived to be dangerous, incompetent, and unwelcome. The mentally ill will prove disruptive; the mentally retarded will slow the line; drug abusers will require expensive supervision and accommodations; insurance rates will go up and productivity will decline.

Once again, there are both collaborative and structural strategies for insuring that the deinstitutionalized do not continue to be idle and unproductive members of the society. On the one hand, planners can utilize a collaborative approach that emphasizes employer education programs. A number of ambitious campaigns, especially those sponsored by the President's Committee on Employment of the Handicapped, have attempted to improve employment prospects for special populations through public service radio and TV announcements (NAB, 1972), pamphlets (NIMH, 1981), and special events (PCEH, 1974) designed to find jobs for offenders, the mentally retarded, disadvantaged youth, etc. Those that have succeeded have tended to focus less on employer attitudes toward the handicapped as individuals and more on employer opinions about how well the handicapped will work out on the job. (Bernatowicz, 1979) Stressing the positive (attendance records, productivity, work longevity, etc.) and countering the negative (insurance rates do not go up, health benefits are not abused, other workers do not object, etc.) in brochures, training films, management seminars, and trade publications can have a small but positive effect on the employment prospects for the deinstitutionalized. At the same time, advances also have been made to strengthen legal mandates and tax incentives. In the absence of enlightened altruism on the part of the business community, deinstitutionalization planners have sometimes turned to more structural solutions: implementation of Federal affirmative action and nondiscrimination statutes (Sections 503 and 504 of the Vocational Rehabilitation Act of 1973) and the use of tax incentives linked to hiring and training policies. (Mainstream, 1975) Indeed, in the wake of Section 503/504 implementation efforts, businesses have shown growing interest in seminars and training programs directed to the sensitive area of hiring and working with the disabled worker. Tax incentives, although currently modest, could be expanded (and supplemented at the State level) to encourage further employer cooperation.

But whether collaborative or structural efforts, or both, are initiated, it will be necessary as well to:

- Support more and better vocational rehabilitation programs. Although many employer beliefs are not accurate, there are often legitimate grounds for concern about work performance. Exoffenders often lack marketable skills, the physically handicapped may have received inadequate educational opportunities, the mentally retarded may require closer supervision, etc. Nothing does more to diminish an employer's willingness to hire the deinstitutionalized than having a handicapped employee referred who has little motivation

or is inadequately prepared.

- Provide followup support services on-the-job. For many deinstitutionalized persons, getting a job proves easier than holding onto it. A sizeable percentage of this population lose their jobs a few weeks or months after obtaining one, and then drift back either to the institutions or to dependence upon public support. Systematic and ongoing support, to both the client and to his or her employer, can be an important part of a successful transition to independence. (Kaufman, 1977) It will also prove valuable for training front-line supervisors, for the person with day-to-day contact with and responsibility for the deinstitutionalized client, and can play a central role in a client's continued job adjustment.
- Involve unions in affirmative hiring campaigns. Reluctant employers frequently argue that other workers on the line will not be comfortable with retarded or alcoholic colleagues. In this regard, it is important to seek the support of union leaders, to encourage them to include the handicapped in their unions, and to insure that the same rights and safeguards are extended to the handicapped as are available to other employees.
- Expand transitional employment programs. One of the most effective mechanisms for simultaneously exposing employers to the work potential of the deinstitutionalized and providing effective rehabilitation programming lies in transitional employment programs (TEP). Designed to offer a "real work" experience to those who need to develop appropriate work habits and/or marketable job skills, TEP is a cooperative venture with businesses and industries willing to set aside individual positions, or even entire operating units, for training site use by a rehabilitation agency. (NARF, 1980) TEP's have proven a successful modality, both in training disabled persons for competitive employment and in educating employers about the productivity of the handicapped.

The Media

The factors already discussed—public attitudes toward the deinstitutionalized, opinions about the success of deinstitutionalization efforts, and response to exogenous factors like inflation and crime—are certainly major determinants of community support. But how are such attitudes, opinions, and responses formed? Several sources are clearly identifiable. A long-standing cultural bias against the disabled, the aged, or other norm violators plays a role, as does the current community experience with the unintended impacts of deinstitutionalization. Research suggests that, in addition, individuals who have been service consumers, or who have close family members or friends who have been involved in treatment, tend to have a more benevolent view of the deinstitutionalized and to respond more positively to community-based services. (Trute and Loewen, 1978) For most people, however, the primary sources of information about the deinstitutionalized are the mass media—newspapers, radio, television, and film.

The populations we are concerned with here do not fare well in the media. The mentally ill are consistently portrayed as violent (Gerbner, 1980); substance abusers are engaged in seemingly endless rounds of criminal activity; the elderly are routinely cast as victims; and the physically handicapped are either objects of pity or heroes of phenomenal valor. Stereotyped images such as these are inaccurate, of course, but there is evidence that many people frequently mistake the media world—even the fictional world of television drama—for real life. It is little wonder, then, that neighborhoods are so frightened. Deinstitutionalization services fare little better than the individuals they serve: newspaper disclosures, television documentaries, and radio talk shows have made the public uncomfortably aware of the failures of deinstitutionalization efforts. Boarding home fires vie with expatient murder sprees for front page headlines. It is these traumatic events that capture the public imagination.

It thus becomes important to work closely with the media to minimize the frequency of portrayals that reinforce negative public stereotypes and to develop more positive—or at least more balanced—images of the deinstitutionalized. Films that feature psychotic killers for instance, do more than offer ex-mental patients personal insult. They deepen the climate of

fear that threatens deinstitutionalization's progress. Deinstitutionalization planners once again may choose between collaborative approaches (educating and assisting the media) and structural solutions (monitoring and pressuring the media). Because of the enormous power of the media in our society, both journalists and dramatists are especially resistant both to structural limitations on what they can and cannot say and to more collaborative approaches that might more subtly influence their perspective. But it is precisely because of that enormous power that deinstitutionalization advocates cannot ignore the destructive messages about community programs and the people they serve that dominate the media. In response, planners and public educators can do the following:

- Work closely with key media to get the "right" story out. The deinstitutionalized are not as threatening as they are portrayed, nor are community programs as ineffective as often suggested. A balance must be established between criticizing the negative coverage received in the past and the inclination of advocates for community care to put a gloss on the future. It is possible that seminars for the media (Wahl, 1980), informational newsletters, and repeated personal contact with media personnel can in the long-run create a new awareness. (Dolan, 1978) Nurturing individual relationships with media representatives (which often means providing accurate, responsive information when they need it) can substantially improve the quality of media coverage. A professionally staffed information center specifically designed for media use would be especially helpful. (PCMH, 1978)
- Provide news and feature stories that suit media needs. It may prove useful to take the initiative, by designing newsworthy events and providing unique feature story ideas. If it is only business as usual, the press can wait for a dramatic suicide or a tragic mugging.
- Monitor the media. Black and Hispanic groups have monitored and changed their media images. Parents have been particularly effective at detailing the incidence and impact of violence in children's television programming, and they too have forced changes in network policies. Advocates of deinstitutionalized populations, it would follow, can monitor media portrayals and seek comparable changes. In fact, some work has already begun to address television images of the elderly and the mentally ill, and this work is likely to expand. Although complaints to the industry are only rarely effective, they can place the media on notice that more balanced portrayals will be expected in the future. This can be especially effective in working with local, as opposed to national, media operators. (Cantor, 1980)
- Act. There are a number of avenues for forcing change. Broadcasting codes and Federal Communications Commission regulations provide for sanctions, but more importantly create an atmosphere of responsiveness to public pressure. Other political tactics can be used. A group of expatients picketed the film "Halloween" and forced its withdrawal from a local movie house. (Minneapolis Tribune, 1979) Action for Children's Television supports a boycott of products from those advertisers supporting particularly violent children's programs. These are not central issues for deinstitutionalization planners, to be sure, but they can be coordinated as part of an overall media strategy.

Broad Scale Public Education

Because efforts to alter negative media images of the deinstitutionalized are only occasionally successful, public educators in the human services often attempt to counter the stereotype of the "dangerous inmate" by undertaking their own informational campaigns. As public opposition has grown, a number of States have recognized the importance of "selling" deinstitutionalization to citizens outside the crisis context of a tense zoning board hearing or a hastily convened community meeting. In trying to move from a purely responsive posture with regard to public education, planners in the field see the need for a systematic approach to broad-scale educational campaigns. In this connection, human service professionals are beginning to examine the techniques of marketing and applying them to the public education tasks they face in approaching communities on behalf of the deinstitutionalized. This application of marketing principles is done with some reluctance, of course, since human service professionals tend to consider themselves "above" crass commercial methods. But over the

past decade there has been a rapid growth in the field of "social marketing," in which the concepts of marketing have been brought to bear on pressing social issues, and service planners, practitioners, and educators are finding that many of those concepts make good sense. (Kotler, 1975)

Several key elements of a social marketing analysis are particularly important in framing public education campaigns. One of the primary social marketing principles is a careful examination of the "product." Marketing deinstitutionalization means marketing the clients that community programs are designed to serve. There is still great uneasiness among professionals in presenting the most seriously disabled to the public—the chronically mentally ill expatient, the profoundly retarded adult, the multiply physically handicapped child—and the tendency is to produce films and brochures that focus on the less severely disabled. The unintended consequence of such an approach is to retain in institutional settings the least acceptable of our clientele. It is useful, then, to recognize the difficulty of marketing a product that is, at least initially, the object of so much public antipathy, which marketing experts describe as a "negative demand" situation.

The task is complicated by uncertainty about what constitutes an appropriate "message." A wide range of options exist, from the traditional reliance on pity and guilt, to a more neutral emphasis on tolerance and fair play, to a stronger advocacy position that places the stress on client rights. One possible solution is to vary the message depending on the target audience. Campaigns oriented to the "general public" are rarely effective. Specially focused presentations to homeowners, employers, potential volunteers, church members, etc., have far more impact. This necessitates varying the "channel" utilized to reach the target audience, from public service announcements, to Chamber of Commerce meetings, to the feature section of the Sunday paper, to the pulpit. And it requires as well shifts in the "source"—the person presenting the information to the public. Too many messages are presented in the name of social service professionals, when other homeowners, celebrities, or consumers would have a more positive effect.

Unfortunately, there is little market research available to help direct planners toward proven answers, but thinking through who is to be reached and how to reach them can make an important contribution to influencing public attitudes. In the past, many campaigns have gone forward too quickly, targeted to the general public, distorted the truth about clients and programs, and played upon themes that are either offensive to clients or insulting to the community. From all of this, however, we have learned some useful lessons, particularly with regard to:

- Media campaigns. The most frequently used efforts have relied upon traditional avenues to get across the deinstitutionalization story. Public service announcements, documentary films, informational brochures and newspaper stories have all been utilized in the past, with varying effect. Several problems occur repeatedly. First, public educators are often unsure of the message they should deliver: should deinstitutionalization be supported for economic, moral, or treatment reasons? Should dangerousness be addressed or avoided? Should the focus be on programs or people? Second, little effort has been made to determine what the public is likely to find believable or acceptable in these messages. (Bloom and Novelli, 1980) Too often human service professionals have promoted messages that, while they appeal to professional values and preferences, are viewed by their target audience as naive, self-serving, or didactic. Third, there has been an inability either to properly fund media campaigns or insure proper distribution of the materials. In a culture innundated by media images, amateurish productions are quickly passed over, with printed materials relegated to waiting rooms and public service announcements broadcast in the early morning hours.
- Public discussion. Media campaigns can either be supplemented or supplanted by opportunities for public discussion. Some administrators encourage residential facilities to send staff and clients door to door in target communities, or to schedule an open house. Others

promote opportunities for community-wide forums, or establish speakers' bureaus that reach out to local civic groups. What is to be most avoided are the difficult public discussions that take place at zoning board hearings (where shouting and accusations often replace rational debate) and community meetings with angry, threatened neighbors unwilling to genuinely exchange views. In such settings the arguments for community care falls on deaf ears; the crisis-generated public meeting is not an appropriate setting in which to challenge long-standing fears and concerns. (Baron, 1979) Public meetings, seminars, and sponsored forums in a planned context can be useful, however. They can help reinforce the commitment of deinstitutionalization advocates and can add new knowledge about deinstitutionalization to the public, particularly if there is press coverage.

- Using volunteers. For many years, volunteer coordinators have stressed that volunteers do more than offer their services to care systems. More importantly, they take valuable impressions and information back to the broader community, where they share what they have learned. It is useful to consider this public education role of the volunteer, and to insure that the experiences of volunteers in institutions and community programs reach family members, friends, and neighbors. The more people with positive first-hand experience with the deinstitutionalized (e.g., as volunteers in a vocational workshop, or as members of a neighborhood advisory board for a halfway house), the more ambassadors of good will that will exist. (Porter-Novelli, 1978)
- Utilizing consumers. The past decade has seen a dramatic rise in consumerism, and increasingly the deinstitutionalized are seeking the opportunity to speak for themselves. The physically handicapped provide the most dramatic example of this, but there are similar movements among expatients of psychiatric hospitals, of the mentally retarded, and of the elderly. These groups are growing in sophistication and articulateness. While such developments should be supported on their own merits, they also offer a public education opportunity, for no one can speak more eloquently about the deprivations of institutional life than those who have experienced it firsthand. A number of moving films that focus on handicapped individuals serve similar purposes (International Rehabilitation Film Review Library, 1980), familiarizing the public with the handicapping condition through a single individual and providing both factual information and personal exposure that can be critical factors in community acceptance.

Planning for Community Support: Special Constituencies

Linked with efforts to provide the general public with a new image of the deinstitutionalized is the recognition that a number of special constituencies also must be addressed. Because these groups both respond to and help shape public opinion, their attitudes toward deinstitutionalization are particularly important.

Professionals

The professional community is far from unanimous in its evaluation of deinstitutionalization. While there is little support for the underfinanced and understaffed institutional facilities of the past, increasing numbers of professionals have expressed doubts that the current system of care in the community offers a suitable alternative. This may stem from professional hopes for deinstitutionalization that were initially unrealistic. (Lamb, 1981) The chronically mentally ill do not make dramatic advances in community settings, exoffenders do not always turn their backs on further criminal activity, and the physically handicapped continue to face often insurmountable physical barriers in the broader community. At the same time, it has been noted that many professionals often exhibit negative reactions to their own clientele (Cohen and Streuning, 1963): mental hospital personnel who do not believe their patients can long survive outside the institutions; counselors in community settings who cannot tolerate

their clients' dependencies; human service workers who do not want to be bothered with the "special" problems of "special" populations.

As a consequence, professionals in many fields are moving more cautiously today, insisting that adequate community services be in place before clients are discharged, and former proponents of deinstitutionalization have begun to reluctantly consider reinstitutionalization as an answer to the inadequacy of community services.

Legal Advocates

Professionals who have begun to have second thoughts about the feasibility of deinstitutionalization are now supported by a number of legal advocates, once in the vanguard of those urging court mandated discharges "with all due speed," but who now fear that what awaits the deinstitutionalized may not be a welcoming, supportive community at all. Similarly, court decisions have begun to swing back toward defining an appropriate role for institutional care. It may be true, of course, that the legal arguments that accompanied the initial attacks on institutional care were overstated, i.e., it may not be either possible or desirable to close all institutions in the foreseeable future. But what was once a bold effort to win basic civil liberties for the institutionalized is now in partial retreat. Planners need to carefully monitor the pendulum's swing to avoid a return to earlier years when citizenship was a virtually meaningless term inside the institution's walls.

Unions

Among the most politically potent voices on the scene are those of union representatives of institutional employees. Indeed, unions like the American Federation of State, County and Municipal Employees (AFSCME) were among the first to raise serious doubts about how well deinstitutionalization programs were working, for both clients and communities. Almost a decade ago AFSCME published a hard-hitting review of deinstitutionalization ("Out of Their Beds and Into the Streets") that railed against the dismantling of Massachusett's juvenile detention facilities. (Santiestevan, 1975) It is not hard to find the basis for union opposition: the phase-down of State institutions clearly means that thousands of persons will lose their jobs, as well as the benefit packages and pension programs that make State employment so attractive. Because community programs are often operated by local government units or by private nonprofit providers, neither the salaries nor the benefits provided are comparable. And because few of these programs are unionized, the unions have struggled to slow or scuttle deinstitutionalization plans in Massachusetts, Pennsylvania, and other large States. It would be a mistake, however, to assume that union opposition is entirely self-serving. Hospital employees believe that many of those forced into the community cannot fend for themselves, and can be better cared for in the institutions to which staff have dedicated their entire careers. Both economic and ideological issues are salient here, and planners would be well advised to respond to union concerns early in the process of phase down. The best programmatic change, of course, would result in upgraded community programs, to defuse union arguments about the crisis in care that results from the dumping of ex-inmates into unprepared communities. Coupled with this should be efforts to meet the unions' more immediate concerns: retraining of institutional personnel for community programs; early retirement programs for those unwilling or unable to make the shift; and comparable salary and benefit packages available in community programs.

Legislators

State and Federal legislators receive a very mixed message. They are sometimes simultaneously urged to act on behalf of deinstitutionalization programs and to blunt its effect on community life. Considerably more attention must go toward convincing legislators to appropriate additional funds for community programs, to pass nonexclusionary zoning legislation, and to strengthen affirmative action programs in employment. Legislators are most

responsive, of course, to their constituents, who they know are interested in decreasing tax burdens and protecting their neighborhoods. But legislators often shape as much as follow public opinion, and it is essential to develop strong, knowledgeable leadership among legislators with a commitment to deinstitutionalization.

The Future of Deinstitutionalization

The challenges of deinstitutionalization are considerable. Many previous sources of support for the movement out of institutions and into community-based alternatives have begun to decline. Public support, which was never strong, has been weakened by rising crime rates and inflation indexes. The prospect for achieving effective deinstitutionalization may be dimming.

A number of avenues are open to deinstitutionalization planners who choose to move ahead. Reasonable siting policies and unambiguous zoning regulations can have a salutory effect. The opening of vocational and social opportunities in the community can be a key to broader public acceptance. Direct work with the media and more professional response to the need to "market" deinstitutionalization should have an impact. Although there are no easy answers for reversing public hostility, it is vitally important that the task be undertaken. What is clear is that deinstitutionalization is a public policy that cannot succeed without public support, for the financial costs and personal risks involved are great and impossible to ignore. The need is to reinvest in deinstitutionalization, rather than to abandon it.

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Closing Comments

Conclusion

A major social phenomenon of our age, deinstitutionalization shares several noteworthy characteristics with other broad social movements which have left their imprint on the American scene. Like the War on Poverty, deinstitutionalization was conceived in a climate of hope and fostered by strong humanitarian values. As with the civil rights movement, its development quickly became embroiled in tension and controversy. Like the feminist and gay rights movements, strong advocate feelings on both sides gave rise to polarization and ultimately backlash. And, like any number of earlier medical and mental health advances also initially heralded as breakthroughs, deinstitutionalization may have promised individuals and communities more than it could deliver.

Almost from the start, the debate among professionals, public officials, and community forces around deinstitutionalization has been active and intense. Stating it in oversimplified terms, its advocates believe that community-based care offers the most effective, humane, and economical approach to meeting the needs of disabled persons while its critics argue that deinstitutionalization's underlying premises were questionable from the outset and that the experience of the past two decades confirms that the approach falls short of achieving its goals.

That such widely divergent views exist among so many professional and community leaders perhaps becomes more understandable when viewed in light of the following considerations, about which, interestingly, adherents of both positions tend to agree:

- The term "deinstitutionalization" has come to mean many things. It may refer to a value system, a set of goals, a process or a result achieved by large-scale discharge policies. Any one of these interpretations may be operative in a given appraisal of deinstitutionalization; which one it is, of course, greatly influences the conclusions that are reached.
- Deinstitutionalization is not directed to a single, homogeneous population but rather to a number of populations, each with clear differences between and within their ranks regarding such variables as needs, characteristics, magnitude, adjustment potential, and community acceptance. These populations include the mentally ill, the mentally retarded, the aged, substance abusers, and juvenile and adult criminal offenders.
- Deinstitutionalization was executed in many States and local communities in a precipitous manner, often for the wrong reasons (i.e., the belief that it would result in tax savings) and almost always without adequate prior planning or provision of needed community-based services. Also overlooked, in most instances, was the systematic preparation of the clients, staff workers, agencies, and communities most directly affected by the deinstitutionalization process.
- The funding resources needed to support deinstitutionalization services have been poorly designed and meager. There has not occurred, at Federal, State or local levels, the creation of predictable and efficient funding mechanisms directed specifically to the needs of clients living in the community and to the agencies that undertake to serve them.

The above considerations may be helpful in providing us with a clearer view of the current and future directions of deinstitutionalization. They support the observation that the movement consists of a mix of high ideals, partially fulfilled promises, and poorly executed planning and coordination efforts. Further, although a reliable assessment of its effectiveness to date is difficult to make, in light of the uneven procedures and resources that have been employed in its implementation, they suggest that deinstitutionalization is neither problem free and thriving nor comatose and about to expire. Rather, the movement seems to have arrived at a kind of plateau, at a more mature stage of development in which its objectives are receiving more rigorous examination and its techniques and procedures more systematic construction.

This monograph was written as the Federal Government critically re-examined the organization and funding of many long-established social programs. According to present indications, many health and social services systems will be markedly revised, and the policy-setting role and financial support for such programs formerly assumed by the Federal Government significantly diminished.

How will these changes affect deinstitutionalization? The final answers must await the completion of the political process, but some reasonable guesses can be made now: the deinstitutionalization movement will continue, those responsible for its performance will be required to exercise greater precision in planning and coordinating services, and, because resources will (probably) be reduced, programs will be subject to stricter accountability in areas of financing and effectiveness.

In principle, these are really not new conditions, since human services agencies ostensibly have been attentive to issues of planning, coordination, and accountability all along. But, in practice, the anticipated changes in the organization of services probably will have a noticeable impact, particularly with respect to the assignment of priority and funds. The importance of developing well-conceived and well-administered community-based services will need to be established all the more clearly and convincingly in the decade ahead. We sincerely hope this monograph will be useful to planners and implementers of deinstitutionalization services in meeting this responsibility and challenge.

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